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ABSTRACT

This document presents an annotated bibliography of 1,008 references on the subject of primary prevention in mental health. The bibliography is divided into 20 sections, each containing cross-references. Section I includes citations providing general perspectives on primary prevention. Section II provides a perspective on publications that discuss issues and debates about primary prevention. Section III presents an overview of how the idea of primary prevention has spread among mental health professionals and workers in allied fields. Section IV focuses on early intervention approaches with children, and section V deals with competence building in children, adolescents, and adults. Primary prevention through parent training is considered in section VI. Section VII concerns the prevention of child abuse, section VIII focuses on couples and families, section IX considers primary prevention with specific populations, and section X addresses primary prevention of specific mental disorders. Crisis intervention and preventive interventions following a specific stressful life event are covered by sections XI and XII. Section XIII focuses on social support, section XIV considers primary prevention through changing the social context, and section XV examines how communications technologies can disseminate primary prevention information. Section XVI deals with mental health promotion. Section XVII is organized around specific settings for the implementation of primary prevention programs. Articles in section XVIII concern issues of developing, coordinating, and evaluating primary prevention programs. Section XIX addresses issues of training and section XX includes a cross-reference list of citations published before 1960. An author index is included. (NB)

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primary prevention in mental health: an annotated bibliography

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Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

primary prevention in mental health: an annotated bibliography

by

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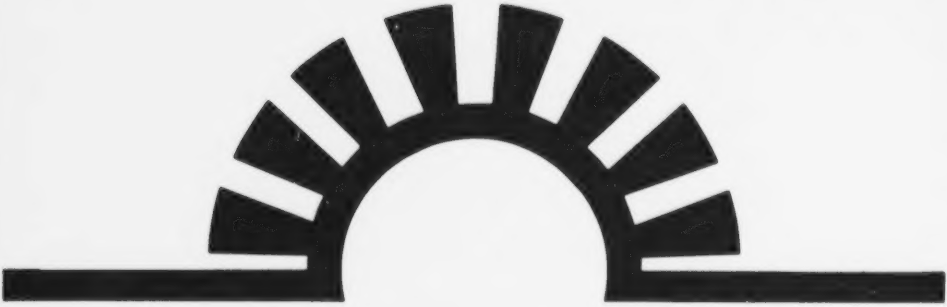

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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This bibliography is the 10th issue in the Prevention Publication Series. The purpose of this series is to disseminate and exchange information on prevention activities, especially primary prevention, in the mental health field; stimulate development of prevention projects in mental health, public health, and other human service facilities; encourage the training of mental health workers in prevention; and promote prevention research. This series includes scientific monographs, conference proceedings, commissioned papers, and other materials that meet a need for information about prevention. Publications in this series will be issued as materials and manuscripts are developed. The views expressed in these publications are those of the author(s) and do not necessarily reflect the official position of the National Insitute of Mental Health or any other part of the U.S. Department of Health and Human Services.

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6. A Guide to Evaluating Prevention Programs in Mental Health
7. Preventing Stress-Related Psychiatric Disorders
8. Psychiatric Epidemiology and Primary Prevention: The Possibilities
9. Stressful Life Event Theory and Research: Implications for Primary Prevention

The editors are Mr. John C. Buckner and Ms. Sara J. Corse, doctoral candidates, and Edison J. Trickett, Ph.D., Professor of Psychology, Department of Psychology, University of Maryland, College Park, Maryland.

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Dr. Barbara J. Silver, Special Assistant to the Director, NIMH, and Dr. Stephen E. Goldston, Director, Office of Prevention, served as the NIMH Project Officers.

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Foreword

An oft-expressed frustration of prevention advocates, researchers, practitioners, and academicians has been the difficulty in identifying and accessing relevant primary prevention literature. This situation has been attributed to several factors: (1) this literature appears in scores of professional journals; (2) many such publications are not readily available to mental health workers; (3) the volume of published material on primary prevention has proliferated dramatically in recent years; and (4) the communications network among primary prevention specialists, which serves to share information, is a relatively new phenomenon.

One apparent way to deal with the difficulty in locating primary prevention reference material is to compile and distribute to the field an extensive bibliography on the subject. This carefully crafted, annotated bibliography, presenting the literature in an orderly, systematic fashion, genuinely fulfills this recognized need. It covers a wide range of issues, programs, debates, and perspectives on primary prevention. Beginning with literature providing overview statements about the field, it next focuses on articles about how the concept of primary prevention has permeated the mental health professions and goes on to outline the many substantive areas of research and practice that currently define the field. From the prevention of child abuse, to early intervention programs for children and their families, to the roles played by community mental health centers and schools as sites for prevention, the bibliography organizes and highlights the state of knowledge and practice in primary prevention.

As an invaluable guide for both the researcher and practitioner, this bibliography is unique in its comprehensiveness and focus. For students, it offers a readily available introduction to the broad scope of activities related to primary prevention. Further, this extensive resource guide is proof that primary prevention has amassed a body of literature--principles, concepts, theories, and research--of sufficient scope and breadth to require its own bibliography. Moreover, its thousandfold citations demonstrate that primary prevention has become a widespread and viable pursuit for those mental health professionals committed to reducing the incidence of mental and emotional disorder and psychological dysfunction and to helping people develop the strengths and competencies necessary for a fulfilling life.

The National Institute of Mental Health is pleased to make this bibliography, which was commissioned by the NIMH Office of Prevention under its mandate to contribute toward formulating national goals and priorities for the prevention of mental illness and the promotion of mental health, available to the mental health community.

Stephen E. Goldston, Ed.D., M.S.P.H.
Director, Office of Prevention
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and
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Prevention Publication Series

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Preface

The compilation of this annotated bibliography of published work in the broad area of primary prevention in mental health represents an attempt to organize and systematize writings in a field that has been steadily gaining momentum over the past decade. Neither this preface nor this bibliography outlines the various intellectual and political developments that have contributed to the concept of primary prevention; however, many of the citations in the bibliography provide such a historical perspective. Rather, it is the function of an annotated bibliography to clarify a dispersed body of literature, to provide a general set of organizing categories that highlight where activity in this field is occurring, and to aid in the development of systematic inquiry by outlining what has been done already in a form meaningful to both researchers and practitioners. This last function may be of particular value in view of the many disciplines, sites of intervention, and populations of interest involved in prevention efforts.

Creating an annotated bibliography necessitates decision rules for the inclusion of citations. In areas where significant disagreement about the boundaries of the field exist--as they do in the area of primary prevention--the basis for such decisionmaking criteria can seem arbitrary and risk appearing excessively narrow, broad, or simply incorrect. On the one hand, setting arbitrary boundaries early in a field's evolution can serve a stifling function and may erroneously lead to an impression of what the field is, should be, or could be. On the other hand, it would have been both heroic and in the footsteps of Sisyphus had we followed the potential conundrum previously experienced by Kessler and Albee (reference #86):

> During the past year we found ourselves constantly writing references on scraps of paper and emptying our pockets each day of notes on the primary prevention relevance of children's group homes, titanium paint, parent-effectiveness-training, consciousness raising, Zoom, Sesame Street, the guaranteed annual wage, legalized abortion, school integration, limits on international cartels, unpolished rice, free prenatal clinics, antipollution laws, a yogurt and vegetable diet, free VD clinics, and a host of other topics. Nearly everything, it appears, has implications for primary prevention, for reducing emotional disturbance, for strengthening and fostering mental health (p. 560).

Several guidelines served as inclusion/exclusion rules for the bibliography. While we believe these rules represent reasonable compromises, we recognize that other decisions could have been made with equal rationale. However, readers should know the authors' biases.

First, the bibliography is designed to highlight *primary* prevention. This decision dictated the omission of much high-quality research on secondary prevention. The boundaries between primary and secondary prevention were, of course, not always clear. For example, with many preventive interventions, particularly those that target "high-risk" populations, it can be difficult to judge whether they more accurately represent primary or secondary prevention. Where there was ambiguity, the authors most often erred on the side of including the citation, believing that at this time the inclusion of most of this gray area would be appropriate.

Second, the bibliography is oriented toward primary prevention in the area of *mental* rather than physical health. While there is no intent to minimize the interdependence of mental and physical health, the decision was made to include research on primary prevention and physical health only when the implications for mental health outcomes had been considered as well. Though this caused the exclusion of some important work in the more general area of primary prevention--such as the Stanford Cardiovascular Risk Research Project--it made the task both more focused and feasible.

Third, we did not require a citation that dealt with primary prevention to pinpoint preventing a particular mental disorder. This requirement would have eliminated the majority of citations in this bibliography. Primary prevention in mental health was considered both in terms of the prevention of specific disorders and the enhancement of competencies related to mental health in general. Thus, attempts at increasing self-esteem or an ability to solve interpersonal problems, although they do not specify the diagnostic entity or pathological state to be prevented, are seen as having potential fortifying effects that presumably increase the robustness of persons in dealing with a variety of stressful life events.

Fourth, we decided to emphasize preventive *interventions* over work in the so-called generative aspect of prevention, that body of research and thinking that forms the knowledge base out of which preventive interventions arise. Clearly, there are large gray areas in this distinction as well. For example, the bibliography includes a section on primary prevention and social support. There is a vast literature on social support. However, for purposes of the bibliography, our emphasis was on those social support citations that discuss preventive interventions or which draw clear and direct implications for preventive interventions. While the gathering of information on the knowledge bases of varied preventive interventions is a useful, indeed critical task, it has not been the focus for this bibliography. Rather, the emphasis on primary prevention has been more directly related to the translating of knowledge into intervention programs or ideas.[1]

Fifth, for a variety of reasons, research and intervention programs that can be seen as preventive in nature have not always been described by the authors in the language of prevention. When authors clearly expressed the view that an intervention they were describing or proposing had clear-cut primary prevention implications, the citations were included. If an intervention was not described by the author(s) in these terms, but nevertheless potential for primary prevention could be inferred, we were forced to make a decision based on our own assessment. With review and conceptual articles (those not having descriptions of interventions) similar issues arose, with the ultimate criterion a judgment about whether primary prevention in mental health was central to the discussion or just briefly mentioned.

Sixth, the bibliography includes only published documents, omitting dissertations or working papers on primary prevention. This decision was made on pragmatic grounds and in the belief that, particularly with dissertations, significant work will eventually be published. Seventh, we excluded a small number of articles that were not written in English.

Our literature search took several different forms. First, computer searches were conducted, primarily using the NIMH facilities. Next, key review articles and books covering the area of primary prevention were examined for their own content and for their lists of references. In select areas we contacted knowledgeable persons to solicit their ideas about relevant references.[2] Finally, a number of publications, particularly book chapters, that were not identified by the computer searches or by other means, were found through extensive library searches. These latter strategies of obtaining references should not be overlooked in the compilation of a comprehensive bibliography; our experience has been that the computer searches tapped only a moderate percentage of the actual number of appropriate existing publications.

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[1] In a similar vein, with one exception, we did not include publications that formed the literature of the Mental Hygiene Movement (1908-60). While this movement had prevention of mental illness as an important goal, we did not see this literature as central to the present-day knowledge base of primary prevention. However, awareness of this literature, and in particular the one reference we did include (#122), is important in having a full historical perspective of modern-day primary prevention in mental health in this country.

[2] We are indebted to Drs. Bruce Dohrenwend, David Biegel, and James Kelly for their contributions in this regard.

From these varied approaches we have generated an annotated bibliography of 1,008 references on the subject of primary prevention in mental health. These published works span three decades, with the earliest articles dating from the 1950s. An exponential increase has occurred in the last decade, with virtually every mental health-related profession developing a prevention literature. The bibliography, while not exhaustive, is extensive, particularly through 1982. Additions after that date were made as time, salience, and publication deadline allowed. Taken together, however, these thousand articles comprehensively portray the dominant issues, themes, paradigms, and substantive research and practice efforts in the field.

The annotated bibiliography is divided into 20 sections, each containing relevant cross-references. The annotations are factual, rather than evaluative or critical, summaries of the contents of each item. Section I includes citations that provide a variety of general perspectives on primary prevention, including definition issues, overviews of the field, and broad theoretical and conceptual discussions. Section II provides a perspective on publications that discuss the issues and debates about primary prevention, including pragmatic concerns such as funding and the merits of primary prevention. Section III presents an overview of how the idea of primary prevention has spread among mental health professionals in varied fields and among persons in allied fields.

The substantive portions begin with section IV, which focuses on early intervention approaches with children. In addition to conceptual papers describing the rationale for early intervention, this section includes citations on preventive interventions during pregnancy as well as work with populations of children at-risk for the development of emotional disturbance. Section V deals with competence building in children, adolescents, and adults as an approach to primary prevention.

Primary prevention through parent training is the subject of section VI. In addition to conceptual papers presenting the case for parent training as a general strategy, a number of parent-training programs are described. Section VII addresses the prevention of child abuse and includes both screening and interventions involving families and children considered at-risk for abuse. Section VIII includes approaches to primary prevention among couples and families that are designed to enhance their functioning. Primary prevention with specific populations is the subject of section IX, which includes work with varied minority groups such as American Indians, blacks, and Hispanics, as well as preventive interventions with the elderly. Articles within section X address the primary prevention of specific mental disorders, particularly schizophrenia and depression.

Crisis intervention as a primary prevention strategy and preventive interventions following a specific stressful life event are the topics covered by sections XI and XII. The former includes not only conceptual articles on the relevance of crisis intervention as a primary prevention approach but also research and program descriptions of crisis intervention with individuals and families and help in coping with natural disasters. The latter likewise includes conceptual articles as well as preventive intervention references on stressful life events.

The role of social support as a preventive intervention is covered in section XIII. In addition to conceptual discussions and descriptions of programs based on social support, this section includes articles that view self-help groups from a primary prevention perspective. Section XIV focuses on primary prevention through changing the social context--in this instance, modifying social and physical environments and social systems, and developing resources in the community. Section XV includes articles on how communication technologies such as television, radio, and interactive television can serve to disseminate information as part of a primary preventive intervention.

Mental health promotion is the subject of section XVI. These articles stress the promotion of positive mental health as a meaningful primary prevention approach in addition to and/or separate from approaches that focus more on the prevention of some end-state mental disorder. Section XVII is organized around specific settings for the implementation of primary prevention programs and includes descriptions of preventive interventions in a variety of settings. Primary prevention programs and activities emanating from community mental health centers are emphasized, as are schools as a central site for primary prevention activities. Issues in developing, coordinating, and evaluating primary prevention programs are the basis of articles in section XVIII. Citations in section XIX address issues of training for persons involved in providing primary prevention services, including the training of mental health professionals, other professionals not in mental health fields, and nonprofessionals. Finally, section XX includes a cross-reference list of citations published before 1960.

While not wishing to overextend the boundaries of a field that some feel is already too diffuse, it is necessary to reemphasize that this annotated bibliography is based almost entirely on existing work that is self-defined as primary prevention. By adopting this approach, we have neglected entire substantive areas of research and practices that are of obvious relevance to primary prevention but do not usually speak in the voice of primary prevention. Community development and community organizing may represent such areas. In addition, there are disciplines such as epidemiology where the links to primary prevention are only currently consolidating and that will, over time, surely make more substantive contributions. Yet at present, the contributions from epidemiology, as represented in the current literature, are rather meager. Finally, there are cognate areas, such as mental health consultation, that are manifestly preventive in nature but have their own set of annotated bibliographies dating back over many years. We have chosen to omit them, but wish to acknowledge their relevance. We view this effort, then, as one designed to organize literature in a particular area but which should not be seen as intending to preempt other areas of work or the possibilities for primary prevention to grow and change in the future.

An annotated bibliography of this scope could not have been completed without the aid and support of many people. The following persons from the University of Maryland provided assistance in abstracting articles: Pamela Luttig, Robin Rosenberg, Merrill Mead-Fox, Bill Mansbach, Jennifer Smith, Elizabeth Cousins Buckner, Eleanor Lehan, Michele Feder, Rochelle Anderson, and Grace Petro. Dr. Stephen Goldston, who conceived and initiated this project, was supportive with advice and access to his extensive library of primary prevention publications. Part of the work on this bibliography was completed while one of the authors (E.J.T.) was on sabbatical leave at Yale University's Institution for Social and Policy Studies; appreciation is extended to Yale University and to the University of Maryland's General Research Board.

The task of tracking an evolving field is an ongoing one, and the authors wish to invite readers to share any reactions about the inclusiveness, means of categorization, or other ideas that will further clarify the nature of primary prevention. Correspondence may be addressed to the first-named author.

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I. Perspectives on Primary Prevention

A. Definitional Articles

Articles in this section are primarily focused on definitions of primary prevention, including definitions of the different levels of prevention and means of differentiating various types/levels of prevention programs. Articles appearing elsewhere in the bibliography that discuss definitional issues but do not focus on them are cross-referenced.

1. **Adam, C.T. (1981). A descriptive definition of primary prevention. *Journal of Primary Prevention, 2,* 67–79.**

This theoretical paper links prevention activities and wellness activities in a context of social action. It attempts to define prevention by describing the essential characteristics of the prevention process. Six characteristics are identified: proactive, generic, developmental, experiential, systemic, and collaborative. A number of prevention programs that appear to illustrate one or more of these characteristics are cited. The need for such a process as an approach to many contemporary individual and social problems is assumed. The author's intention is to provide program planners and funders with a usable theoretical base for developing and evaluating specific programs. (Author abstract) © Human Sciences Press.

2. **Bloom, M. (1980). A working definition of primary prevention related to social concerns. *Journal of Prevention, 1,* 15–23.**

An interpretive content analysis of two dozen representative definitions of primary prevention from the 1960s to the present is presented based on an interdisciplinary literature review. Six themes that emerge include: (1) models of causation; (2) the time dimension; (3) the object of the directed prevention; (4) positive and negative events with anticipated or unanticipated outcomes; (5) active or passive strategies of prevention; and (6) evaluation as primary prevention related to social concerns.

3. **Goldston, S.E. (1977). Defining primary prevention. In G.W. Albee & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. I: The issues* (pp. 18–23). Hanover, NH: University Press of New England.**

The article differentiates the different levels of prevention (primary, secondary, tertiary) and discusses primary prevention activities as falling into two categories: health promotion and specific protection. Within a public health theory approach, a definition of primary prevention is given followed by an elaboration of why this means of conceptualization is useful. The author argues that the goal of primary prevention should not be the prevention of mental illness per se but the prevention of maladjustment and maladaptation and the promotion of mental health by increasing levels of wellness among various defined populations. Lastly, the onset of a more favorable climate for primary prevention at the Federal level is discussed.

4. **Perlmutter, F.D., Vayda, A.M., & Woodburn, P.K. (1976). An instrument for differentiating programs in prevention—primary, secondary and tertiary. *American Journal of Orthopsychiatry, 46*, 533–541.**

The design of an instrument that differentiates among programs in primary, secondary, and tertiary prevention is described. A list of 30 specific programs falling into each category was developed. The description of each program incorporated variations on three dimensions: (1) target group; (2) technique; and (3) goals of the program. When experts and administrators rated the programs, 28 of the 30 items had significant agreement. When the three prevention levels are considered, there is little variation between secondary and tertiary levels. The primary prevention category had the greatest dispersion on number of agreements and was also the type of program that received the greatest amount of agreement.

5. **Shamansky, S.L. & Clausen, C.L. (1980). Levels of prevention: Examination of the concept. *Nursing Outlook, 28*, 104–108.**

The construct of levels of prevention as used by health nursing professionals is examined. A review of the literature is provided in order to present various definitions of levels of prevention. Bower, for example, defines primary prevention in mental health as an intervention that promotes mental and spiritual robustness or reduces the prevalence of learning and behavior disorders. It is noted that if community health nursing plans to continue to use the levels of prevention, a consistent understanding of the terms primary, secondary, and tertiary prevention is necessary. Specific dimensions that differentiate among preventive programs in the areas of health behavior, developmental patterns, and copying resources are explored. It is concluded that levels of prevention have become jargon-laden terms which unnecessarily complicate health care.

See also: 18, 26, 29, 49, 50, 66, 67, 86, 163, 192, 235, 243, 283, 889, 910.

B. Theoretical — Conceptual Articles

Articles that discuss current concepts, contribute original perspectives, and provide theoretical ideas regarding prevention are grouped in this section. Other articles through the bibliography make similar contributions but are more keenly focused in another, more specific, content area of the primary prevention literature and are thus cross referenced.

6. **Adler, D.A., Levinson, D.J., & Astrachan, B.M. (1978). The concept of prevention in psychiatry: A reexamination. *Archives of General Psychiatry, 35*, 786–789.**

This article examines current concepts of prevention and offers a new approach. Prevention has different meanings and functions in the four major task areas of psychiatry: medical, rehabilitative, social control, and humanistic. Constructs of primary and secondary prevention are most useful in the medical task area. However, efforts at primary prevention of mental illness can have only limited effectiveness when so little is known about etiology. Secondary prevention is central to the medical caring tasks, where early diagnosis and treatment may lead to successful outcome. Tertiary prevention of disease and primary prevention of developmental defect are the work of the rehabilitative task area. The application of models of prevention in the social control and humanistic task areas has led to serious confusion. ©APA.

7. **Adler, P.T. (1978). A prevention parable revisited. *American Journal of Orthopsychiatry, 48*, 394–395.**

The parable in prevention folklore of pulling bodies out of the river until someones decides to go upstream to stop whomever or whatever is throwing them in is expanded upon in this short article. The author alludes to the theoretical and practical complexities and difficulties involved in actually preventing the bodies from falling into the river. The author's message is that there are multiple reasons why there is psychopathology and there are multiple strategies that could be implemented to prevent different manifestations of mental disorders.

8. **Albee, G.W. (1979). The next revolution: Primary prevention of psychopathology. *Clinical Psychologist, 32,* 16-23.**

There are many similarities between primary prevention of mental illness and public health efforts to fight physical diseases. Both use epidemiological studies to investigate the possible causes of disease, and both employ the techniques of eliminating noxious agents and strengthening the host. For mental disorders there is greater difficulty than for physical disorders, since there is no one-to-one correspondence between cause and effect (e.g., a given type of stress may produce varied reactions in different people). The health industry establishment resists prevention efforts, since it emphasizes and profits by technological treatment of diseases. In mental health research, as in cancer research, most money is spent on trying to find a chemical cure for the diseases, and environmental factors that are known to promote the illnesses are not opposed. Primary prevention is often aimed at mass media, administrative policies, or legislation in an effort to change social situations that promote psychopathology, such as poverty, discrimination, underemployment, undereducation, and sexism. It also promotes the teaching of coping skills and the establishment of support groups. ©APA.

9. **Albee, G.W. (1982). A brief historical perspective on the primary prevention of childhood mental disorder. *Journal of Children in Contemporary Society, 14,* 3-12.**

The author discusses the need for new models of childhood mental disorders and considers the implications of a new social-causation/competency model that can lead to revolutionary changes in the whole mental health field. ©APA.

10. **Asmore, R.D. (1975). Societal and individual orientations toward prevention. In. A. Milunsky (Ed.), *Prevention of genetic disease and mental retardation* (pp. 51-63). Philadelphia: W. B. Saunders.**

In this article, the author proposes a set of principles aimed toward increased interest in and conceptualization of prevention and then discusses the implications of these principles. The author suggests that a comprehensive prevention program should include both the general adult population and children and should involve medical professionals as well. Methods of obtaining the involvement of each of these three groups are presented. Donald Campbell's "experimenting society" is suggested as a basis and program for such efforts.

11. **Beier, E.G. (1969). Preventive measures in the mental health area: Some theoretical considerations on justification and a fantasy about the future. In C.J. Frederick (Ed.), *The future of psychopathology* (pp. 193–211). U.S.A.: Little, Brown & Company.**

This paper begins with a discussion of the concept of maladjustment that is primarily related to deviation from social norms, which vary from society to society. Prevention, then, "is really an attempt by society to have its cake and eat it at the same time," in that its intent is to compensate for the inevitable costs of any social norm; i.e., that persons unable to meet the requirements for the norm experience maladjustment. The concept of prevention heightens attention on maladjusted individuals and social values, thus constituting a force for societal renewal and examination. Prevention rests first on the value of large-scale research, particularly as it relates to the area of war and peace, acculturation of the disadvantaged, and overpopulation. Community mental health efforts should include involvement with citizens and political structures as part of a participatory education effort. Secondary and tertiary prevention thrusts are also described, with the greatest amount of resources going to work with the normal population, especially through educative work in school systems.

12. **Beiser, M. (1968). Primary prevention of mental illness: General vs. specific approaches. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders* (pp. 84–97). Toronto: University of Toronto Press.**

The author argues that although "specific" approaches to primary prevention seem conceptually more precise, and specific disorders appear more readily preventable, there exists such diagnostic and nosological "fuzziness" in psychiatry that such an approach is not necessarily more effective than a general one. Discussing the high prevalence of mental disorder among a sample of 284 adults in rural Nova Scotia, it is demonstrated that the bulk of the diagnoses in this sample concern the disorders whose etiology is least clear--neuroses and personality disorders. Specific approaches to prevention attempt to deal at close range with control of the physical and psychological environment, and crisis intervention. A broader approach, at the level of the community, treats the social system as a semiorganic organization, which, when functioning adequately, performs functions necessary for the survival and well-being of its members. Variations in degree of community integration or disintegration have been shown to be related to prevalence of mental disorder. Specific interventions are dependent on the broad community concerns and values.

13. **Bloom, B.L. (1965). The "medical model," miasma theory and community mental health. *Community Mental Health Journal, 1*, 333–338.**

Current practices in the field of community mental health are examined to determine the extent to which the so-called "medical model" is actually being utilized. In many respects it is shown that the time-honored miasma theory model is more appropriate in understanding these practices. Miasma theory is described and contrasted with the medico-biological model with respect to its pertinence for understanding present ideas of the taxonomy of emotional disorders, principles of diagnosis and treatment, and theories of primary prevention. Some implications of miasma theory as a community mental health model are suggested. (Author abstract modified)

14. **Bloom, B.L. (1979). Prevention of mental disorders: Recent advances in theory and practice. *Community Mental Health Journal, 15*, 179–191.**

The current status of theory and practice of primary prevention of mental disorders is reviewed. Basic concepts and definitions are introduced and the existing knowledge base is examined. Recent advances in conceptions of primary prevention are described, and some general issues not yet resolved are identified. In particular, the importance of the growing shift of interest from predisposing factors in emotional disorders to precipitating factors, and the shift from the search for disorder-specific causes to the search for general, nonspecific causes are underlined. (Author abstract modified)

15. **Bloom, B.L. (1982). Advances and obstacles in prevention of mental disorders. In H.C. Schulberg, & M. Killilea (Eds.), *The modern practice of community mental health* (pp. 126–147). San Francisco: Jossey-Bass.**

This is a revision and an updated version of an earlier article (abstract #14). The author first specifies the meanings of the three levels of prevention: primary, secondary, and tertiary. Clarification of the meanings of disease prevention and health promotion are also given. A brief review of psychiatric disorders of known etiology which can be prevented is given. Such disorders are grouped into the categories: (1) poisons, (2) infections, (3) genetic, (4) nutritional deficiencies, and (5) injuries to the central nervous system and general systemic disorders. The author outlines differences between a general and a specific disease prevention paradigm. The former is built on the idea of preventing psychological disorders through a more effective control of stress; the latter rests on the idea of preventing disorders by understanding the specific etiological process of the disorder. The author then touches upon the conceptual underpinnings of various prevention strategies such as early intervention, stressful life events intervention, social competence building, and changing the level of social support individuals receive. Finally, the author addresses various theoretical and practical barriers that stand in the way of the further development of primary prevention activities. Such barriers include: (1) a lack of national policy regarding the enhancement of mental health, (2) a lack of necessary funding to support knowledge base prevention research, (3) too much emphasis on disease prevention instead of health promotion, (4) lack of active collaboration among professionals, and (5) a lack of interest in prevention by the mental health establishment because of its investment in treatment for which it is able to be reimbursed financially. The author suggests the formation of an agency that is solely concerned with health promotion-primary prevention activities.

16. **Bower, E.M. (1963). Primary prevention of mental and emotional disorders: A conceptual framework and action possibilities. *American Journal of Orthopsychiatry, 33,* 832-848.**

This paper proposes a theoretical framework for understanding some goals, methods, and problems of the primary prevention of mental and emotional disorders. The necessity of major social overhaul, the political tradition of personal independence and privacy in the United States, the possibility of covert yet purposeful social resistance to prevention, and the overemphasis on curative-rehabilitative interventions by clinicans are each discussed as impediments of the primary prevention of mental disorders. The goals of primary prevention are defined as the enhancement of "mental and emotional robustness" or the reduction of "the incidence and prevalence of mental or emotional illnesses in the population at large"; the discussion of these focuses on the necessity (for mental health) of the effective functioning of the individual with maximum ability to adapt to his/her environment. Services and people in actual or potential need of services are classified so as to suggest a functioning methodology for prevention. Primary prevention is considered as involving action within those classifications of services and people not yet experiencing abnormal difficulties, and the method goals of such action are presented as being threefold: enhancing biological robustness of individuals by strengthening agencies involved in prenatal and early infant care; increasing the flexibility of the agencies serving these people, so that such agencies may affect a greater variety and number of persons in the population; and assisting primary institutions in planning social techniques that increase individuals' ability to manage stressful conditions.

17. **Bower, E.M. (1977). Mythologies, realities, and possibilities in primary prevention. In G.W. Albee & J.M. Joffe (Eds.),** ***Primary prevention of psychopathology, Vol. I: The issues*** **(pp. 24–41). Hanover, NH: University Press of New England.**

The story of the ancient Greek mythological figures Asclepius (God of Medicine) and his daughters Iaso, Panakeia, and Hygeia is presented in the context of how these figures represent different approaches to medicine and healing. Iaso and Panakeia are representative of the treatment oriented approach to medicine, whereas the daughter Hygeia is representative of the more ignored health promotion philosophy. The article goes on to explore 'realities' in prevention, including the public health paradigm. Finally, projects in preventive public health, in particular early screening and intervention programs such as Head Start and programs based on the KISS (Key Integrative Social Systems) model, are discussed both in terms of their potential and how they might be improved.

18. **Brown, B.S. (1969). Philosophy and scope of extended clinical activities. In A. J. Bindman & A. D. Spiegel (Eds.),** ***Perspectives in community mental health*** **(pp. 41–53). Chicago: Aldine.**

The roots of community mental health are traced to public health and mental hygiene. The parameters of public health applications to mental health are described, along with some of the problems of translating the concepts of prevention of physical illness into the field of mental health. The levels of prevention--primary, secondary, and tertiary--are defined, contrasted, and explored for their implications for preventive and rehabilitative intervention with individuals and communities. With an emphasis on primary prevention (health promotion and prevention of specific problems), the author discusses the value of prevention as well as the differing philosophies and competition for limited resources that provoke conflict between advocates of rehabilitation and advocates of prevention.

19. **Caplan, G. (1964).** ***Principles of preventive psychiatry.*** **New York: Basic Books.**

This book discusses the philosphy and recent history (to 1964) of the community mental health movement in the United States. The prevention, treatment, and rehabilitation of the mentally ill and mentally retarded is considered a community, not individual, responsibility. Recent developments in psychoanalysis, especially ego psychology and the work of Bowlby, have exerted a great influence on this approach to prevention, which employs active, reality-based methods. In addition, it presents a model for primary prevention that distinguishes between biological, psychological, and sociocultural factors which constantly influence mental health and factors which operate suddenly, at periods of crisis in the life of the individual. The nature and consequences of intervention by the normal social field and by professionals are discussed. In addition, the author demonstrates the manner in which this model can be used to develop a comprehensive program of primary prevention. Naturally occurring transition points can be used to help the individual cope with crisis and resist mental disorder by improving his or her reality-based adaptive responses. Methods of implementing primary prevention, both at the individual level and the social level, are illustrated and discussed.

20. Caplan, G. (1980). An approach to prevention intervention in child psychiatry. *Canadian Journal of Psychiatry, 25*, 671-682.

This article proposes a conceptual model for primary prevention. Its five elements are (1) risk factors, (2) intermediate variables, (3) competence, (4) crisis intervention, and (5) social support systems. The paper summarizes recent preventive intervention efforts and evaluative studies that focus on these elements in seeking to reduce psychiatric disorders in child populations. These include: (1) the reduction of risk factors through mental health consultation and collaboration by mental health clinicians with child care workers and administrators; and (2) the improvement of competence in children at risk by special educational programs with children and their parents that seek to enhance their cognitive and emotional problem-solving and coping skills. ©APA.

21. **Christmas, J.J. (1975). Prevention: Problems in decision-making and implementation in mental health and mental retardation services.** ***Bulletin of the New York Academy of Medicine, 51***, **162-168.**

Questions basic to the prevention of mental illness, strategies and models appropriate to prevention, methods of prevention, and qualifications of practitioners are discussed. Primary prevention relates to changing the socioeconomic environment and modifying or altering those negative external forces that influence human growth and development. It is pointed out that the stresses of a changing society are such that concerns of mental health cannot be separated sharply from social issues or from the socioenvironmental aspects of health care, education, and employment. Such an orientation assumes that plans will be made for the services needed by an entire population group, not only those individuals who are identified as patients or clients by themselves or others. In this formulation, planned social, educational, and psychological interventions recognize and utilize the support systems and social networks of the environment.

22. **Cohen, R. (1978). Prevention reconsidered: Assets, liabilities and alternatives. In S.J. Apter (Ed.), *Focus on prevention: The education of children labeled emotionally disturbed* (pp. 119-135). Syracuse: Syracuse University Press.**

This paper articulates and describes a variety of issues related to prevention. The viability of the basic notion of prevention has, in this author's experience, been questioned, and its definition is in need of clarifying. Some problems with the prevention model are then discussed, including the problem of specifying the desired state of functioning of individuals, the problem of value subjectivity inherent in this issue, and the complexity involved in assessing old areas of personal functioning. A model of prevention based on the concepts of needs, resources, and competence is proposed, and a hypothetical case illustrating the application of the model is included. This model highlights the importance, in preventive interventions, of planning and coordination, formal and informal resource networks, advocacy, skills and supports, and community education and institutional change.

23. **Cowen, E.L. (1967). Emergent approaches to mental health problems: An overview and directions for future work. In E.L. Cowen, E.A. Gardner & M. Zax (Eds.), *Emergent approaches to mental health problems*, (pp.389-455). USA: Meridity Publishing Company.**

The author states that any responsible efforts directed at overcoming the mental health difficulties of modern society should start with a reaffirmation of the enormity and complexity of such problems. Next, and perhaps most central, is the need for effective conceptualization, since program definition, implementation, articulation, and research should rest logically on such a base. Many of the shortcomings in our present mental health structure are attributed to inadequate conceptualization. Two conceptual approaches to mental health are presented. The medical model is shown to fall short of the present and future demands of mental health; the preventive model is presented as a viable alternative, since the realities and demands of our present mental health situation suggest prioritizing comprehensive, preventively oriented models. The role definition, task importance, and cost-benefit issues concerning nonprofessional workers in the mental health field are also presented. Finally, the problems of inadequate mental health research and the urgency for serious and comprehensive research are delineated.

24. Cowen, E.L. (1980). The wooing of primary prevention. *American Journal of Community Psychology, 8*, 258–284.

Issues in the science and practice of primary prevention in mental health are discussed. The evolution of primary prevention in mental health from the dominant disease containment model to its present state is reviewed and problems in terminology and usage are discussed. Knowledge sources are then delineated in terms of: (1) knowledge gathering mode (empirical or naturalistic/clinical); (2) content direction (building psychological health or preventing maladjustment); (3) intentional (arising from programs designed to change behavior); or (4) incidental (deriving from relationships among many independent variables and dependent adjustment measures). Three preventive approaches are then identified and examined in terms of their thrust, structural and organismic dimensions, and content. Finally, the state of the art in research and programming in the areas of mental health education, social systems analysis and modification, skill training, stress reduction and coping, and support systems and networks is reviewed.

25. Cowen, E.L. (1982). Choices and alternatives for primary prevention in mental health. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 178–191). (DHEW Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.

A historical overview of the predominant paradigm shifts in the mental health field is discussed including the transformations from a concern with humanitarian reform, to the psychodynamic revolution, to the community mental health revolution, and finally to the upcoming emphasis on primary prevention. Both extrinsic and intrinsic barriers to an adoption of the primary prevention model are discussed. Current limitations and future directions for the field are suggested.

26. Cowen, E.L. (1983). Primary prevention in mental health: Past, present and future. In R.D. Felner, L.A. Jason, J.N. Moritsugu & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 11–30). New York: Pergamon Press.

The author makes distinctions among the terms "prevention," "prevention in mental health," and "primary prevention" in order to clear the confusion among them that inhibits the development of primary prevention in mental health, the focus of the chapter. Intrinsic deficiencies in the field's early unfolding are seen as having significantly retarded its development. Ways in which the situation can be improved include clarifying the essence of primary prevention in mental health and how it differs importantly from other preventive ventures, and documenting via rigorous research the impact of primary prevention intervention. A distinction between the beauty of the *idea* of primary prevention and the beauty of clearly demonstrated positive results of intervention is stressed.

27. **Conyne, R.K. (1983). Two critical issues in primary prevention: What it is and how to do it. *Personnel and Guidance Journal, 61*, 331-334.**

Discusses primary prevention of mental health disturbances in colleges. Primary prevention has two goals: to reduce the incidence of emotional stress and to promote emotional robustness. Directions from public health, end-state, and stressful life variable models, assessment of populations at risk, and primary prevention program components are discussed. End-states refer to states to be prevented such as drug abuse or suicide; stressful life variables refer to factors that may precipitate such end-states, such as the initiatives necessary to make friends or the stresses resulting from the environment.

28. **Duhl, L.J. (1963). The changing face of mental health. In L.J. Duhl (Ed.), *The urban condition: People and policy in metropolis* (pp. 59–75). New York: Basic Books.**

The author first reviews the development of the field of mental health and its evolution toward an ecological orientation. This ecological orientation considers the community, factors in the environment, and prevention in its approach. The author comments on an increased interest in attempts to promote mental health rather than simply treating the mentally ill. The author then reviews the types of preventive measures (primary, secondary, and tertiary) that can be implemented in a community setting. Finally, the author discusses the role psychiatrists should play as consultants and trainers with caregivers in the community.

29. **Felner, R.D. (1983). Preventive psychology: Evolution and current status. In R.D. Felner, L.A. Jason, J.N. Moritsugu & S.S Farber (Eds.) *Preventive psychology: Theory, research and practice* (pp. 3–10). New York: Pergamon Press.**

In this chapter, the author presents a brief history and definition of preventive psychology, along with an overview of the book. While claiming roots in community psychology and other specialties in psychology, preventive psychology is described as a broader field encompassing psychologists from diverse backgrounds who are doing preventive intervention, research, and theory development. This volume is designed to provide an integrating framework for the field of preventive psychology with the goal of guiding future preventive efforts.

30. **Glaser, E.M. (1981). There are no panaceas—But let's look at some promising developments. In J.M. Joffe & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 190–207). Hanover, NH: University Press of New England.**

The article discusses basic strategies for addressing problems in family relations, schools, and work settings. The author advocates a preventive approach that involves implementing interventions that are proactive and that can be of help to large groups of people. In order to develop knowledge necessary for such interventions, the author argues for state-of-the-art knowledge syntheses in various fields and a more effective utilization in favor of improvement programs which involve the recipients of help in problem identification followed by their participation in problem solving.

31. **Goldston, S.E. (1978). A national perspective. In D.G. Forgays (Ed.), *Primary Prevention in psychopathology, Vol. 2: Environmental influences* (pp. 25–32). Hanover, NH: University Press of New England.**

Four specific, distinct frameworks for conceptualizing and classifying primary prevention efforts are proposed. The first involves a medical approach focused on conditions of known etiology, which are possible to prevent by "specific protection" interventions. The second is the primary prevention of mental illnesses of unknown etiology. The third is the primary prevention of emotional distress, maladaptation, maladjustment, needless psychopathology, and human misery. The last is the promotion of mental health. The major national achievements in the area of primary prevention in 1976 are discussed, as are the gaps, deficits, and problems areas. National priorities for the following year are summarized.

32. **Gorman, M.L. (1971). Primary and secondary prevention: A frame of reference. In D.E. Anderson (Ed.) *Identifying suicide potential* (pp. 57–61). New York: Behavioral Publications.**

Using suicide as an example, the author defines primary prevention as a community concept which involves lowering the rate of the disorder in the population by counteracting harmful circumstances before they have had a chance to produce illness. Inherent in primary prevention are improvements in helping resources and reduction in harmful environmental conditions. Primary prevention work to date has been mainly confined to improving the helping resources. Malfunctioning institutions that contribute to the harm of individuals are left to themselves. There is a question as to whether etiological knowledge is sufficient to warrant intervention with and modification of social forces. The greatest concentration of preventive work is seen in the secondary mode. Secondary prevention refers to the activities involved in reducing the prevalence of a disease entity by case finding, early diagnosis, and intervention. Secondary prevention is hampered by a seeming inability to reach many of the people most in need of help.

33. **Gruenberg, E.M. (1958). Mental health. In H.R. Leavell & E.G. Clark (Eds.), *Preventive medicine for the doctor in his community* (pp. 400–432). New York: McGraw-Hill.**

This chapter begins with a description of the magnitude of the mental health problem in the United States and discusses similarities and differences in mental-disease prevention and physical-disease prevention. The value of understanding the natural history of mental disorders is stressed, and a variety of possible factors in the prepathogenesis of several disorders are mentioned, including failure of self-realization, inadequate parent education and understanding, lack of community integration, inadequate opportunities for personal growth, and social insecurity. The main value of understanding natural history lies in its implications for prevention. The chapter concludes with examples of ways in which preventive interventions can address the various possible factors in prepathogenesis mentioned above.

34. **Guerney, B. 1980). Treatment as prevention: An essay. In H. Staulcup (Ed.), *Primary prevention in social work* (pp. 445–55). St. Louis, MO: Washington University Press.**

The medical model, which views emotionally troubled people as being ill, is contrasted to an educational model or preventive model. It is suggested that the medical model, which includes within it a disease model, has been applied inappropriately to people who have no biochemical disorders, germs, or scar tissue, and that it is the inappropriate transposition of concepts, terminology, ways of dealing with people, and ways of presenting the profession to the public that has created problems. Other aspects of the medical model involve taking a case history, extensive testing and gathering background data, and the implicit contract between the provider of services and the person who is receiving the services. The educational model for delivering mental health services is directed at developing psychosocial literacy, i.e., teaching people how to monitor and guide their own behavior and teaching people how to coordinate their needs and desires with those of others. Instead of diagnosis, the client would set priorities in line with a chosen value system. In place of the concept of therapy or treatment, the alternative model offers the concept of skill training or education.

35. **Hollister, W.G. (1977). Basic strategies in designing primary prevention programs. In D.C. Klein & S.E. Goldston (Eds.), *Primary prevention: An ideas whose time has come* (pp. 41–48). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Goverment Printing Office.**

Basic strategies in designing primary prevention programs were discussed in a paper presented during the NIMH/NAMH Pilot Conference on Primary Prevention held April 2 through April 4, 1976. Stress model strategies are presented as a guide to conceptualization of goals and program design in primary prevention. Stressors--those stimuli which threaten survival, threaten emotional security, or defeat expectations and coping abilities--may be identified within vulnerable populations and are subject to intervention on a clinical or group level of activity. Four major primary prevention strategies are identified, outlined, and exemplified. They are: (1) stressor management--the elimination, modification, or amelioration of stressors; (2) stressor avoidance--removal of vulnerables from exposure; (3) stress resistance building- enhancement of individual or group coping capabilities; and (4) stress reaction management--decreasing inappropriate reactions to stress.

36. **Jason, L.A. (1980). Prevention in the schools: Behavioral approaches. In R.H. Price, R.F. Ketterer, B.C. Bader & J. Monahan (Eds.), *Prevention in mental health* (pp. 109–134). Beverly Hills: Sage.**

A coherent, conceptual system for behavioral mental health preventive interventions in schools is presented, and concrete examples of this approach are given. Models of mental health service delivery, both the traditional community mental health service approach and the community psychology approach, are explicitly defined. Specific, person centered, primary preventive approaches and a range of compatible behavioral technologies are delineated. The relatively unexplored potential of preventive environmental interventions is examined. Critical issues germane to primary prevention in schools, including the feasibility of utilizing supports systems, larger scale interventions, and receptivity for preventive interventions, are discussed.

37. **Kagan, A. & Levi, L. (1971). Adaptation of the psychosocial environment to man's abilities and needs. In L. Levi (Eds.), *Society, stress, and disease, Vol. 1: The psychosocial environment and psychosomatic diseases* (pp. 399–404). Cambridge: Oxford University Press.**

A model for psychosocially mediated disease is proposed in this article. It is contended that, at least theoretically, disease may be prevented at any of a number of stages articulated in the model. Thus, environmental stressors might be removed, modified, or avoided; preventive intervening variables might be increased or disease-disposing intervening variables might be decreased; physiological mechanisms might be interrupted; and precursors of disease might be treated so that they do not develop into overt disease. Each of these preventive methods is elaborated and some general examples are presented. As specific examples of situations possibly warranting preventive action now, marriage, childrearing, child care, working life, and society and the aged are discussed, and some general prevention methods are proposed. It is noted that these propositions are of a hypothetical nature, and thus ongoing action must be evaluated as it is undertaken.

38. **Karlsruher, A.E., Jensen, K., & Nelson, G. (1979). Psychiatric patients' views of strategies for the prevention of problems in living. *Professional Psychology, 7,* 53–60.**

The authors investigated the opinions of 50 psychiatric patients (aged 10 to over 51 years) on how their psychological dysfunction could have been prevented and about the emotional impact of common interpersonal and environmental events. Changes in interpersonal relations and social-community factors were mentioned as ways to prevent dysfunction approximately three times more often than changes in their own personality. Several interpersonal and social-community factors were identified as being particularly emotionally harmful, and preventive strategies suggested by these findings are discussed. ©APA.

39. **Kelly, J.G. (1968). Toward an ecological conception of preventive interventions. In J.W. Carter, Jr. (Ed.), *Research contributions from psychology to community mental health* (pp. 75–99). New York: Behavioral Publications.**

This paper presents four principles from field biology as a basis for developing research on social environments. A specific example of the application of these principles is the author's research on coping behavior of adolescents attending high schools that vary in their social structures. This research is described by the interrelationships of four types of variables (Individual Coping Styles, Conceptions of Adaptive Roles, the Social Setting, and Environmental Exchange). Following this discussion is a presentation of preventive interventions designed for two types of high schools based upon the knowledge of these ecological principles. (Author abstract)

40. **Lemkau, P.V. (1956). Freud and prophylaxis.** ***Bulletin of the New York Academy of Medicine, 32,*** **887–893.**

This paper describes several ways in which Freud's work, through its effect on how we think about human behavior, has been of fundamental importance to the broad area of prevention or prophylaxis. The author cites six tenets in prophylaxis that Freud contributed: (1) Behavior is caused and the causes may be modifiable so that undesireable behavior may be avoidable. (2) There is a motivation of emotional reaction. (3) The maturation process is orderly and predictable at times. (4) Development involves stress as a concept embedded in the idea of developmental tasks. (5) The maturation of the personality takes place in and is modified by significant emotional relationships, and parent-child relationships are of great import. (6) The culture makes a difference and has meaning for the individual as well as the group. (Author summary modified)

41. **Lemkau, P.V. (1956). Prevention of psychiatric illnesses.** ***Journal of the American Medical Association, 162,*** **854–857.**

In this paper the author distinguishes between two general groups of illnesses: those in which there is one outstanding and overwhelming cause (largely diseases of bacteriological or viral origin), and those which arise within the body itself and in which there is probably not one but a series of causes acting together. It is proposed that there are differential success rates of prevention between these two groups, the single cause diseases being more successfully prevented. Problems in the prevention of mental illnesses are attributed to several factors: only some psychiatric illnesses are the result of a single cause, while others have no observable single cause; the extraordinary fluidity of the field of psychiatric treatment has greatly out-paced the ability of research and theory to keep up; and findings of epidemiological research have introduced a variety of debilitating personal and cultural life experiences as factors in psychiatric illnesses. The hypothesis that individual and cultural stresses lower a person's threshhold for the appearance of illness is discussed, with emphasis on the implications of this hypothesis for the prevention of psychiatric illnesses.

42. **Lemkau, P. (1965). Prevention in psychiatry. *American Journal of Public Health*, *55*, 554–560.**

The author presents a broad discussion of several general issues in preventive psychiatry. Every model of pathological process produces diseases with psychiatric symptoms. Any programs aimed at prevention of disease will prevent development of psychiatric symptoms, whether directly or indirectly. In connection with prevention psychiatry, however, the model most often alluded to is that of psychological or environmental factors: emotional conflict, environmental stress, and psychological deprivation. Although nonspecific, each of these offers opportunities for preventive action. Emotional conflict can lead to a wide range of reactions, from strengthening of the personality at milder levels to serious mental disorder. Both educational approaches and "anticipatory" thinking can help to hold conflict to optimum levels. Environmental stress is dealt with in different ways by various societies. Britain, for example, employs the welfare state, while in the United States, public housing, social security, health insurance, public health programs, and other methods are used. Psychological and social deprivation, which may lead to emotional disorder and mental retardation, may be combatted through programs that enrich the affective and educational life of children before they have reached certain critical ages.

43. **Lemkau, P.V. (1966). Prospects for the prevention of mental illnesses. *Mental Hygiene*, *50*, 172–179.**

In this paper, the proposition that "mental illness" is not a single, simple entity is discussed and adopted. It is concluded that the use of a single term ("mental illness") for a plurality of psychiatric conditions has misdirected the pursuit of prevention and treatment, such that we have been seeking one program when multiple programs are needed. It is argued that psychology has introduced notions making it impossible to conceive of diseases of the "mind" and diseases of the body in any sense independently. The effects of various physical conditions on mental performance are discussed, illustrating that there are many kinds of mental illnesses, with many different programs for prevention. Problems with prevention programs are discussed, particularly those illustrating program effectiveness. The phenomenon of early stimulation deprivation is briefly examined and implications for prevention based on the stimulation model are presented.

44. **McPheeters, H.L. (1976). Primary prevention and health promotion in mental health. *Preventive Medicine, 5,* 187–198.**

Despite frequent pleas for mental health programs to devote more resources to primary prevention, mental health programs remain overwhelmingly oriented to treatment. Prevention is given low priority because many psychiatrists who are leaders in the mental health field are focused on a medical-pathological model of prevention that has limited usefulness in mental health and because the guidelines for a social-behavioral model are not always clear. A model for conceptualizing and programming primary prevention and promotion in all of the human services is offered with special attention to mental health functioning. Strategies for both primary prevention and promotion may be directed to individuals or to the environment, but, in either case, the targets and the strategies must be clearly identified. Prevention strategies are directed toward persons in normal situations of growth and development. For either prevention or promotion, the most widely effective strategies are those that require the least personal cost and effort--usually the environment. Prevention and promotion both depend on clear assessment of the stresses and needs and must be evaluated. Programs are often too global or too diffuse to be effective or credible. Working in closed social systems and sharp evaluation will help correct these problems. (Author abstract)

45. **Meyers, A.W., Craighead, W.E., & Meyers, H.H. (1974). A behavioral-preventive approach to community mental health. *American Journal of Community Psychology, 2,* 275–285.**

A behavioral-preventive model of community mental health derived from the recent developments in community sociology and the educationally oriented, empirical approach of behavioral psychology is presented to counteract the inadequacies of existing models. The relevant behavior modification literature is reviewed. It is suggested that the goal of the model be the development of self-controlling communities. (Author abstract modified)

46. **Munger, R.L. (1979). Unthinking prevention. *Journal of Clinical Child Psychology, 8,* 87–88.**

The relationship between advances in primary prevention and the development of new thinking tools is examined. To a great extent the limits of psychological preventive capabilities are due to an inability to radically alter the way humans think about things. Primary prevention is concerned with the promotion of mental health. As long as programs are conceptualized in terms of mental health, they will be resisted by the public. Thus prevention requires an interdisciplinary effort involving economists, psychologists, urban planners, and others. Since mental health outcomes are significantly affected by diverse areas, a central task force should be formed to coordinate activities from all sources. A first step would be the formation of a community-based organization to take the initiative in bringing the community together in support of prevention. It is concluded that successful preventive efforts will depend on increased sophistication in thinking in order to set new goals and priorities for the future.

47. Murphy, G. (1960). The prevention of mental disorder: Some research suggestions. *Journal of the Hillside Hospital, 9*, 131-146.

The author states that factors that give rise to mental disorder lie in all the disciplines from genetics and physiology to the social sciences. The author proposes that the course of research in psychopathology should begin with pilot studies viewing each of these factors separately, followed by multifactor approaches. This latter approach is contrasted to the well-defined process of research in the area of disease control, and its need is illustrated by citing a broad spectrum of research in the area of schizophrenia. Some proposals for research on prevention are discussed as well as the costs and gains of this research. Furthermore, the author emphasizes that future research in prevention should stress an understanding of the process of normal development and health.

48. Perlmutter, F.D. (1982). New directions for mental health promotion. In F.D. Perlmutter (Ed.), *New directions for mental health services: Mental health promotion and primary prevention* (pp. 7-18). San Francisco: Jossey-Bass.

The conceptual problems and implications of the shift from a concern for primary prevention to a focus on mental health promotion are addressed. Originally a public health concept, primary prevention is an activity designed to reduce the incidence of a disorder or the likelihood of its occurrence in at-risk populations. By contrast, mental health promotion is activity designed to increase people's sense of competency, coherence, and control so they can live effective and satisfying lives in a state of social well-being. It is proposed that mental health promotion activities should not be conducted in mental health agencies, which are systems designed to deal with mental illness; rather, this direct service should be delivered within the context of the institutions in society involved with the normal processes of living. The challenge lies in defining the means by which the mental health system can retain appropriate responsibility for this function. A partnership between the mental health system and other front line institutions is advocated, and an attempt is made to define their respective roles.

49. **Price, R.H., Bader, B.C., & Kettterer, R.F. (1980). Prevention in community mental health: The state of the art. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy, and practice* (pp. 9–20). Beverly Hills: Sage**

The authors raise conceptual and definitional issues of tertiary, secondary, and primary prevention. Primary prevention is described as efforts to reduce the incidence of mental disorders and is aimed at essentially normal people believed to be "at risk" for the development of a particular disorder. It is noted that as the field has developed, a shift in interest has occurred from looking at precondition or predisposing factors associated with particular psychological disorders to looking at precipitating factors or stressful life events capable of triggering maladaptive behavior in a proportion of the population. A second shift has occurred from interest in prevention of specific disorders to interest in health promotion. It is suggested that, while it is often implied that health promotion and competence building serve to prevent psychological disturbance, this need not necessarily be the case. Thus, the preventive effects of health promotion must be substantiated empirically. Issues of policy guidelines, research, and evaluation are raised.

50. **Randall, D. (1981). Concepts of health and mental health: Laying the groundwork for intervention. *Canada's Mental Health, 29*, 2–6.**

Key mental health concepts are defined, and some direction is given concerning the relationship between lifestyle and mental health. Defined are the concepts of health, tolerance and intolerance of distress, mental health, prevention, and primary prevention for the field of mental health. It is suggested that it is in the area of coping with conflict and anxiety that the relationship between mental health and physical health becomes apparent. A stress/strain model is considered as being useful if one accepts the notion of encouraging positive resistance as the basis for a positive program in the area of preventive mental health. Areas for activity by those wishing entry to primary prevention activities or for those aspiring to develop primary prevention programs are summarized. In addition, criteria for prevention programs for the Canadian Mental Health Association are suggested.

51. **Reppucci, N.D., Mulvey, E.P., & Kastner, L. (1983). Prevention and interdisciplinary persepctives: A framework and case analysis. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 234–244). New York: Pergamon Press.**

The authors propose multidisciplinary analysis and collaboration among professionals in anthropology, sociology, law, medicine, and education (to name a few) as necessary in developing, organizing, and researching prevention strategies. The case is made for this collaboration as a means for opening up the thinking of preventive psychology and bringing in diverse perspectives when trying to understand social problems and their wide context. The issue of adolescent pregnancy is discussed from the point of view of how such multidisciplinary collaboration might expand our knowledge base and improve our effort to prevent adolescent pregnancy and the medical, financial, psychological, and social costs of this problem.

52. **Sanford, N. (1965). The prevention of mental illness. In B.B. Wolman (Ed.), *Handbook of clinical psychology* (pp. 1378–1400). New York: McGraw Hill.**

The author states that the position of prevention in the mental health field has been somewhat ambiguous. Although it is frequently cited as the ultimate aim of research, it is treated as virtually an afterthought in textbooks and treatises on psychopathology. The historical basis of this ambivalence is briefly traced. One key theme throughout is that the American culture has traditionally accented self-improvement rather than social change, and true prevention was to be achieved through giving enough treatment to those who need it, thus protecting future generations. But as public health specialists moved into the field, there was a new emphasis on the underprivileged and the masses. This new emphasis called for the modification of factors believed to be affecting large segments of the population. This public health approach can utilize socio-psychological and personality theory in its preventive strategies. Furthermore, the utilization of these theories, especially the psychoanalytic personality theory, can be much more efficiently and effectively used at the public health level than at the individual-treatment level. All programs of preventive action should be guided by a set of ideals referring to positive mental health and, more specifically, to what a person might become. A theoretical outline of what is to be prevented, in whom prevention is to take place, and by what means prevention should be effected is presented. The remainder of the discussion groups programs at the national, State, community, and interpersonal levels, with a fundamental distinction maintained between primary and secondary prevention. Implications for the practice, research, and training of the clinical psychologist are considered.

53. **Sanford, N. (1972). Is the concept of prevention necessary or useful? In S.E. Golann, & C. Eisdorfer (Eds.), *Handbook of community mental health* (pp. 461–471). New York: Appleton–Century–Crofts.**

After briefly viewing the public health approach to prevention, the author explores extensively the developmental model in relation to prevention. The need for affective educational programs at all levels is stressed. It is argued that programs aimed at the prevention of particular problems should receive the major portion of the available resources. The main objection to such a reallocation may prove to be practical, i.e., money is more easily raised to prevent or avoid an evil than to provide for some imagined good.

54. **Sauber, S.R. (1974). *Preventive educational intervention for mental health*. Cambridge, MA: Ballinger.**

An educational model for treating and preventing mental illness is offered, primarily for the mental health educator, trainer, and practitioner. Included are basic concepts of mental health education for community service personnel and for the lay public and an evaluation of preventive educational efforts.

55. **Seidman, E., & Rapkin, B. (1983). Economics and psychosocial dysfunction. Toward a conceptual framework and prevention strategies. In R.D. Felner, L.A. Jason, J.N. Moritsugu & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 175–198). New York: Pergamon Press.**

This chapter reviews literature on the relationship between economics and psychosocial adjustment, including its link with suicide, major functional disorders such as schizophrenia and personality disorder demoralization, or nonspecific psychological distress and delinquent and criminal behavior. This is presented both at the global level and with attention to the specific findings related to macrolevel and microlevel effects of economic change. The authors propose a conceptual framework that constitutes an ecological analysis of the linkage beween the economy and psychosocial dysfunction. Preventive strategies are outlined.

56. Simon, W.B. (1972). Some issues in the logic of prevention. *Social Science and Medicine, 6*, 95–107.

A typology is developed to analyze some of the local issues of prevention. This typology is based on certain aspects of a specific person's preventive behavior (predicting an undesirable state, knowing about it, and acting on it) and certain aspects of the prevention situation (whether or not the undesirable state is objectively predictable, avoidable, and typically avoided). Only types considered relevant to the rational prevention of distress were discussed. These were divided into correct prevention, overprevention, and underprevention. The excesses of overprevention were stressed since it was felt that the dangers of underprevention were sufficiently well known. It was emphasized that people need to understand that, even though they could not have prevented certain current stressful conditions, they can learn how to anticipate them in the future. Not facing up to such present preventive inabilities often leads to negative practical consequences. Some of the tendencies and pressures resulting in excessive zeal for prevention are also discussed. (Author abstract)

57. Stevenson, G.S. (1956). Public health and the prevention of mental disorder. In G.S. Stevenson (Ed.), *Mental health planning for social action*. (pp. 191–204). New York: McGraw Hill.

The focus of this chapter is on the protection of public mental health and the role of the public health officials in this endeavor. The problem of potential conflicts between social values and preventive methods and the importance of nonsuperficial interventions are discussed. Discriminations between absolute prevention, presumptive prevention, relative prevention, and prevention of relapse are made, and their respective roles in the public mental health are elucidated. The role of public health in the prevention of mental disorders is broadly considered, and some past efforts in this area are mentioned. At the same time, the lack of emphasis on mental health in this primarily medically oriented field is stressed. The author argues that mental health should be a concern of public health in practically every phase of its work, even those phases of disease control and the provision of medical services.

58. Swift, C.F. (1980). Primary prevention: Policy and practice. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 207–236). Beverly Hills: Sage

A reconceptualization of prevention is presented emphasizing the health promotion and disease prevention aspects of primary prevention as distinct from the treatment aspects of secondary and tertiary prevention. The possibility of a separation of prevention and treatment service delivery is considered. The refocusing of prevention efforts from individual to systems is highlighted and its implications for the community mental health movement and the development of new careers in prevention are discussed. These careers include media specialists, epidemiologists, educators, and needs assessors whose disciplines may not fall into the traditional categories of psychiatrist, psychologist, and social worker and who will need skills in working on interdisciplinary, cross-department, cross-agency teams for most cost-effective and beneficial service delivery.

59. **Weinberger A.S. (1980). Contours of primary prevention.** *Canada's Mental Health, 28*, 18–19.

Assumptions underlying preventive intervention within mental health service delivery are considered, and the wisdom of activist leadership and assertive advocacy by mental health workers is addressed. The preventive approach presents a strong argument for an ecological or holistic perspective on humans and mental health. It is suggested that recruiting significant others is an important part of preventive intervention, and that mental health workers should concentrate on being public educators as opposed to public motivators. Implications for the future are included.

60. **Wertlieb, D. (1979). A preventive health paradigm for health care psychologists.** *Professional Psychology, 10*, 548–557.

The author develops a preventive health paradigm for health care psychologists by building on public health and preventive mental health models of primary, secondary, and tertiary prevention. Adoption of a "biopsychosocial" perspective on health and illness is basic to the preventive health paradigm. Examples of preventive health programs are considered along with a wide range of preventive health activities by psychologists in health care settings. ©APA.

61. **Wonderly, D.M., Kupfersmid, J.H., Monkman, R.J., Deak, J.M., & Rosenberg, S.L. (1979). Primary prevention in school psychology: Past, present, and proposed future.** *Child Study Journal, 9*, 163–179.

Reasons for the apparent failure of primary prevention efforts to decrease mental health problems are discussed. Both primary prevention and mental health are similarly nebulous concepts. Beyond this, there has been an impatience for practical and efficient results that has hindered the development of many programs. Other problems include a lack of viable models, few trained preventive specialists, resistance to a focus on primary prevention efforts in mental health clinics, and a conviction that preventive efforts are too expensive to justify their implementation. Preventive approaches continue to be proposed and initiated. The PSI (Prevention Systems Intervention) model suggested in this article is based on the contention that the public school is a most appropriate setting for preventive programming and that the school psychologist is in a position to implement such programs. The PSI model is currently being developed in a preventive specialty in school psychology at Kent State University and has been experimentally employed in several school districts. ©APA.

62. **Zinn, D. (1979). A developmental preventive approach to problems of psychopathology in adolescence. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol 4: Prevention and current issues* (pp. 157–168). New York: Basic Books.**

This paper reviews numerous issues in adolescent development and discusses their implications for preventive interventions. A knowledge of normal development of variations in early, middle, and late adolescence gives insights into the kinds of problems that need to be dealt with to avoid future difficulties. Parent education and educational problem-solving opportunities for the adolescent are critical school experiences that serve an important preventive function. Jobs and job training for many adolescents are also essential to prevent loss of self-esteem and self-worth. Mental health specialists in adolescence can contribute most effectively to prevention through consultation with health, welfare, education, and judicial agencies and institutions as well as social and religious community groups involved with adolescents prior to and during their troubles. (Author abstract modified)

See also: 1, 2, 3, 66, 69, 70, 71, 72, 76, 79, 76, 79, 84, 86, 100, 102, 106, 114, 122, 123, 124, 126, 127, 128, 129, 132, 143, 144, 147, 148, 151, 152, 153, 154, 155, 160, 161, 164, 186, 203, 210, 211, 213, 218, 223, 235, 240, 242, 245, 264, 271, 274, 287, 298, 310, 355, 402, 437, 439, 478, 533, 592, 597, 656, 661, 665, 672, 717, 791, 815, 820, 826, 829, 830, 831, 839, 869, 907, 910, 916, 918, 940, 949, 953, 959, 963.

C. Review — Overviews

This section is a comprehensive listing of articles and book chapters which have reviewed types of preventive interventions. These articles provide overviews of the different methods and strategies that have been or could be implemented in efforts to deal with the primary prevention of psychopathology and the positive development of mental health.

63. American Public Health Association (1962). *Mental disorders: A guide to control methods*. New York: Author.

This publication first reviews the three levels of prevention: primary, secondary, and tertiary. Within what is relevant to primary prevention, the paper first discusses mental disorders of known etiology. While such disorders do not constitute a large proportion of all mental disorders, their effects are very serious. This publication groups disorders of known etiology into five categories: (1) those disorders related to poisoning, (2) disorders which result from infectious agents that affect the central nervous system, (3) disorders brought about by a genetic process, (4) disorders produced by nutritional deficiencies, and (5) general systemic disorders that can produce chronic brain syndromes. Methods of prevention for these types of disorders are reviewed. Additionally, the publication discusses efforts at prevention of conditions of unknown etiology. Here efforts at prevention are conceptually more difficult and still in the beginning stages. Finally, implications for the training of administrators and other mental health specialists in prevention are discussed.

64. Anthony, E.J. (1972). Primary prevention with school children. In H. Barten, L. Bellak (Eds.), *Progress in community mental health, Vol. 2* (pp. 131-158). New York: Grune & Stratton.

The article begins with a short history of the community psychiatry movement and its relationship to concepts of public health. Primary prevention is then discussed, including its emphasis on environmental modification, vulnerability research, the concept of crises, and normal life crises. The importance of epidemiology as providing an approach to data-based primary prevention activities is then discussed, citing as examples epidemiological studies with children. In terms of the sites for primary prevention activity, the school is highlighted because of its impact on the developing personality of the child, and mental health consultation is mentioned as an important modality. Risk research in the school settings is discussed, and its difficulties and complexities stressed. Finally, a school-based crises intervention project designed to prevent the development of emotional disorders in children is presented.

65. **Bjornson, Jr. (1971). Primary prevention: Fact or fiction. In K. Wolff (Ed.), *Cultural factors in mental health and mental illness* (pp. 68–86). Springfield, IL: Charles C. Thomas.**

Primary prevention strategy and tactics aimed at reducing the incidence of mental health disorders in the community are discussed. Concepts basic to primary prevention include the high-risk population, hierarchy of factors, network of factors, crisis theory, anticipatory guidance as emotional innoculation, triage or selectivity of change agents, use of community resources, use of epidemiological surveys, the growth and development factor, and the concept of supplies. Each of these is analyzed. A brief history of Jefferson Community Mental Health/Mental Retardation Centre Task Force on Primary Prevention is given. Problems of primary prevention include political involvement, sociocultural conditions, lack of equal opportunities in the welfare and educational and medical care systems, and lack of knowledge. Problems of educational programs for parents on how to raise children are discussed.

66. **Bloom, M. (1981). *Primary prevention: The possible science*. Englewood Cliffs, NJ: Prentice Hall.**

This 200-page book explores the topic of the primary prevention of physical and mental health disorders in great detail. Individual chapters contain discussions of (1) definitions of primary prevention, (2) the history of primary prevention, (3) examples of primary prevention programs for children and adults, (4) different theories, paradigms, and strategies for primary prevention, (5) the monitoring and evaluation of prevention programs, (6) social epidemiology and screening, (7) the costs and benefits of primary prevention, and (8) barriers to and criticisms of primary prevention.

67. **Bolman, W.M. (1969). Toward realizing the prevention of mental illness. In L. Bellak, & H.H. Barten (Eds.), *Progress in community mental health, Vol. 1*, (pp. 203–231). New York: Grune & Stratton.**

Although the concept of prevention has been formally introduced to the mental health professions, they have not yet shown their acceptance of this concept through its general application. However, as a result of the enormous discrepancy between mental health needs and available resources, preventive approaches and programs have gradually been developing in theory and practice. The author describes several views of prevention methods compiled from reports from 20 States. These broad views include: prevention as mental health education, as the effective treatment of children and families, as an approach to reorganizing existing service models, and as program for reduction of the incidence, prevalence, or severity of a specified mental disorder. While prevention and community psychiatry have a natural affinity, it is noted that community psychiatry is predominantly treatment oriented, and not really prevention-oriented. Primary, secondary, and tertiary prevention types are briefly defined, and three general types of approaches of prevention (community-wide, milestone, and high-risk) are presented. Some current projects are presented, exemplifying preventive approaches being taken at this time.

68. Bolman, W., & Westman, J. (1967). Prevention of mental disorder: An overview of current programs. *American Journal of Psychiatry, 10*, 1058–1068.

The authors present an overview of presently available approaches to the prevention of mental disorder, essentially giving the reader a number of references dealing with specific topics and problems. It is their contention that, despite some vagueness and a need for more research, there already exists a growing body of knowledge and experience with implications for prevention of mental disorder. They approach the literature by classifying prevention as either child-centered, family-centered, or society-centered. The range of child-centered programs includes those for reducing incidence of prenatal and perinatal casualty, programs for children with special defects (e.g., blindness, retardation), programs oriented toward child-parent relationships, and programs for hazardous events in childhood. The importance of an intact, supportive family in psychological development is reflected in programs oriented to the problems of intact families, families in crisis (due to death, loss of income, etc.), of "culturally deprived" families, and of families in a state of disorganization. Society-centered prevention is a very complex and very broad area, and the type of programs subsumed under this category include mental health planning projects, community organization and development, education, and social action.

69. Caplan, G. (1961). *An approach to community mental health*. New York: Grune & Stratton.

This book presents an overview of concepts and activities relating to prevention. First, a conceptual approach to psychiatry is described, and examples of various types of preventive action are presented. Next, ego psychology is discussed and its relationship to crisis theory and crisis intervention described. Pregnancy, mother-child interaction, and the mental health aspects of family life are then discussed as relevant to a variety of preventive interventions. Following these discussions, the role of nurse, social worker, and family doctor are cited as potentially central ones for delivering preventive interventions. Finally, several principles of comprehensive psychiatry are outlined, including aspects of programming for mental health across the levels of primary, secondary, and tertiary prevention.

70. **Caplan, G. & Grunebaum, H. (1967). Perspectives on primary prevention: A review.** ***Archives of General Psychiatry, 17*****, 331–346.**

The authors focus on three types of prevention: primary, secondary, and tertiary; these are defined and described. A discussion concerning short-term and long-term aspects of the preventive model is also presented. The nature of long-term resources involves physical, psychosocial, and sociocultural resources. The preventive implications of short-term or "crisis" factors are discussed with an orientation toward applications, including reducing severity and providing services.

71. **Cowen, E.L. (1973). Social and community interventions.** ***Annual Review of Psychology, 24*****, 423–472.**

The literature in the area of social and community interventions is reviewed. The importance of preventive work in mental health, which has been somewhat slighted in favor of traditional rehabilitative and restorative efforts, is stressed. The major conceptual models are the medical model, which emphasizes repair and rehabilitation of dysfunction, and the preventive model, which stresses building for health. Epidemiology is discussed as a key tool of a systems approach. Person-oriented approaches include a focus on early childhood influences, crisis intervention programs, consultation activities, and the increased use of nonprofessional persons in the mental health field. Newer approaches featuring school environment intervention programs and inner city and community action activities are examined.

72. **Cowen, E.L. (1977). Baby steps toward primary prevention.** ***American Journal of Community Psychology, 5*****, 1–22.**

In the presidential address delivered at the 84th Annual American Psychological Association Convention, the concept of primary prevention in mental health is examined, including differences in abstract definition of the term and concrete illustrations. Consideration is given to what mental health personnel are equipped to do in the primary prevention area. It is noted that virtually any event or structure can affect one's psychological well-being; thus, the independent variables that could potentially affect well-being must be separated into those for which mental health disciplines have knowledge and competence bases, and those for which such bases do not exist. It is suggested that two important areas meet this criterion: (1) the analysis and modification of impactful social systems and (2) competence training. Examples of recent work in these areas are cited, and linkages reported between system qualities and competence as independent variables, and dependent measures of adjustment and well-being. It is noted that both areas are targeted impersonally to the many, rather than to manifestly disturbed individuals. It is suggested that such developments may offer possibilities for restructuring mental health's classic definition of mandate (to combat pathology) by tapping skills close to the special backgrounds and training of psychologists.

73. **Cowen, E.L. (1977). Primary prevention misunderstood. *Social Policy, 7*, 20–27.**

The author cites the mistaken tendency to recognize too many programs (including his own) as examples of primary preventive interventions. It is suggested that more collaboration take place between mental health specialists and members of other disciplines such as architecture, engineering, and urban planning. The author considers the analysis and modification of social environments and competence building as two fruitful avenues for further primary prevention efforts.

74. **Cowen, E.L. (1978) Demystifying primary prevention. In D.G. Forgays (Ed.), *Primary prevention of psychopathology, Vol. 2: Environmental influences* (pp. 7–24). Hanover, NH: University Press of New England.**

"Slippage" between abstract definitions and concrete illustrations of primary prevention and what mental health people are, and are not, competent to do is discussed. It is suggested that when the knowledge base of a particular area is lacking, mental health professionals should be limited to learning more or to working in closer collaboration with people who know more. Two areas where we possess or can readily acquire the necessary competence and technology include: (1) the analysis and modification of social systems that affect human behavior and (2) competence training. Examples of recent work in these areas have been cited, and linkages have been reported between system qualities and competence as independent variables and criteria of adjustment and well-being.

75. **Eisenberg, L. (1963). Preventive psychiatry. *Annual Review of Medicine, 13*, 343–360.**

Despite a lack of specific knowledge concerning etiology of mental disorders, programs aimed at prevention can be devised from epidemiological data about susceptibility and transmission. Specific disorders can thus be controlled to some extent with present knowledge. There are numerous possible programs for primary prevention of mental disorder. Genetic counseling can prevent conception of individuals likely to inherit serious hereditary disease. During pregnancy, the fetus can be protected against syphilis, rubella, and poor nutrition in the mother, as well as against excessive x-ray radiation. "Unwanted" children can be prevented by easy availability of birth control education and materials. The dangers of childbirth--obstetrical trauma, excessive narcosis, anoxia--all are potentially preventable. During childhood, proper nutrition and protection against toxins and infection are important. At the psychological level, nonspecific mental retardation may be preventable by increasing the degree of stimulation of children's environments, while the literature on maternal deprivation offers clear indications as to how that problem may be prevented. Measures to help the disorganized family, the adolescent in crisis, the bereaved, and the aged are all presently feasible. Programs of secondary and tertiary prevention have so far received the most support, and thus a fairly wide range of such services are already available. The author describes a number of such programs and suggests possible innovations.

76. **Eisenberg, L. (1981). A research framework for evaluating the promotion of mental health and prevention of mental illness. *Public Mental Health*, *96*, 3-19.**

This article outlines a "research framework" for prevention beginning with the assertion that priority setting for resource allocation is a political process. Prevention research carries not only opportunity but political risk as well, including the possibility of promising more than can be delivered, the difficulty of measuring distant outcomes as criteria of success, and the need to specify modest gains. Both reducing the burden of illness and promoting health are stressed, and a variety of topics are noted as important to the general good of prevention and promotion. These include migration, social networks as buffers, mitigating the effects of acute loss, and family planning. In addition, in the area of specific protection against psychiatric disorder, several other areas are mentioned, including ways of preventing mental subnormality, metabolic screening of newborns, genetic counseling, minimizing enviornmental hazards to the brain, primary prevention for mental disorders of aging, and preventing the evil effects of racism on mental health. After brief mention of secondary and tertiary prevention, the author concludes with implications for public policy.

77. **Ewalt, J.R., & Ewalt, P.L. (1976). Preventive methods and mental health programs. In B. Wolman (Ed.), *The therapist's handbook: Treatment methods* (pp. 262–276). New York: Van Nostrand Reinhold.**

Primary and secondary preventive methods used in mental health programs are described, emphasizing that such programs are based on the premise that a strategy for health improvement should include personal health care, environmental control measures, and measures of influencing health related behavior. Primary methods are disucssed under two headings: (1) those that alter the individual through some biologic or metabolic manipulation within the body (such as vaccination), and (2) those that alter the environment (improvement of family relationships and socioeconomic conditions). Secondary prevention includes early detection, intervention, and treatment and is usually done at the point of first contact with the caring professions (family physicians, clergymen, school counselors, and service agencies). Trends in recent years have been toward enlarging the scope of community involvement and concern in preventing mental illness, as evidenced by increased availability of services to the citizen, particpation in mental health planning, and manpower adaptations.

78. **Ewalt, J.R., & Ewalt, P.L. (1983). Preventive methods and mental health programs. In B.B. Wolman (Ed.), *The therapist's handbook: Treatment methods of mental disorders* (2nd Ed., pp. 318–337). New York: Van Nostrand Reinhold.**

The author briefly reviews two basic methods of primary prevention: (1) those methods that alter the individual through some biologic or metabolic manipulation within the body and (2) those methods that alter the environment. The author argues that it is unlikely that any single genetic, chemical, psychologic, or social factor could cause diverse and serious problems on growth and development or that correction of any one could prevent illness. The author argues for caution in the use of the term primary prevention of mental illness. Continued support of research to identify causes and preventive methodologies is advocated, but diversion of mental resources into predominately environmental manipulation is argued as not yet justified by scientific findings. Such environmental manipulation, while not necessarily preventing mental disorder, may be justifiable on the grounds of improving the quality of human experience. The authors go on to discuss efforts at secondary prevention. Issues in early detection and early intervention are discussed. The authors conclude the article with a discussion of various theoretical, political, professional, and practical issues involved in the provision of mental health services in the community.

79. Goldston, S.E. (1977). An overview of primary prevention programming. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 23–40). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.

An overview of primary prevention programming was presented at the NIMH/NAMH Pilot Conference on Primary Prevention, held April 2 through 4, 1976. A brief history of positive mental health and primary prevention concepts is presented. The tenets of community mental health are reviewed and frameworks for conceptualizing primary prevention within the community health context are examined, which include primary prevention of mental illness of known or unknown etiology, primary prevention of emotional distress and maladjustment, and the promotion of mental health. Primary prevention is defined and its objectives are outlined. Major preventive strategies include strengthening individual capacities and modifying the environment. The current state of the field is summarized together with barriers to prevention activities. Factors contributing to the emergence of a primary prevention focus are discussed. A model for primary prevention programming based on work with sudden infant death syndrome is presented. Principles of program development and gaps and problems are also discussed.

80. Gruenberg, E.M. (1953). The prevention of mental disease. In R.H. Dysinger (Ed.), *Mental health in the United States (Annals of the American Academy of Political and Social Science, Vol 286)* (pp. 158–166). Philadelphia: American Academy of Political and Social Science.

The article briefly reviews current programs and strategies in the prevention of mental disorders. The effectiveness of primary prevention has been demonstrated in the prevention of certain organic mental disorders such as general paresis due to syphilis and pellagra psychosis. Other strategies of primary prevention are discussed and evaluated including parent education, marital counseling, eugenic sterilization, social security, psychoanalysis, and leadership and morale building. The article also discusses secondary and tertiary preventive efforts.

81. Gruenberg, E.M. (1957). Application of control methods to mental illness. *American Journal of Public Health, 47,* 944–952.

By advocating a comprehensive, public health approach to mental illness, the author reviews what can be done in terms of primary, secondary, and tertiary prevention of mental illness, through agencies or structures that currently exist. Within maternal and child health agencies, the author cites as examples *prenatal care*, measures which can prevent illnesses prior to birth; control of *environmental* hazards such as poisoning and iodine deficiency; and good nutrition. Within welfare departments and social service agencies, the author suggests the adoption of policies that promote the emotional health of children rather than disrupt family life and possibly damage children as some current policies do. Finally, he speaks to secondary and tertiary prevention and the many types of organizations that can effect positive change through their policies and structures alone. The author suggests that only by preventing the preventable disorders, terminating the terminable disorders, and reducing disability experienced from mental disorders will mental disorders among the people of a community be controlled.

82. **Gruenberg, E.M. (1959). The prevention of mental disorders. *Journal of Chronic Disease, 9*, 187–198.**

The author discusses knowledge relevant to the prevention of mental disorder which was available to practicing physicians in 1958. A number of infections capable of causing central nervous system damage are known and are preventable or curable. These include syphilis, measles, mumps, meningitis, encephalitis, and others. Early intervention may completely prevent the development of mental disorder. Poisons, including lead in paint, industrial toxins, alcohol, and even medicine, may cause mental disorder, and proper control of these substances may consequently prevent its occurrence. There are a number of nutritional deficiencies--especially vitamin B deficiencies--capable of causing psychotic symptoms, such as pellagra and Wernicke's encephalopathy. Proper diet will prevent these from occurring. Genetic disorders are at present not directly preventable, but genetic counseling for parents may decrease the possibility of birth of children with such problems. Psychogenic mental disorders may be prevented through the presence of a positive emotional attachment to the parents, and through adequate provision for physical needs during the child's years of development. Various methods of secondary and tertiary prevention are available for the treatment of mental disorders that have already begun to develop.

83. **Gruenberg, E.M. (1980). Mental disorders. In J.M. Last (Ed.), *Maxcy-Rosenau public health and preventive medicine* (11th Ed., pp. 1301–1358) New York: Appleton-Century-Crofts.**

This book chapter first reviews epidemiological prevalence rates of mental disorders in the United States. Following this is a discussion of the scope and methods of prevention. The different meanings of prevention are discussed. The chapter concentrates on what is currently known about prevention of mental disorders of known etiology such as mental disorders caused by infectious organisms and poisons. Reviews of secondary and tertiary prevention are also given as well as a brief account of the historical development of American psychiatric care.

84. **Jason, L.A., & Bogat, G.A. (1983). Preventive behavioral interventions. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research & practice* (pp. 128–138). New York: Pergamon Press.**

Behavioral approaches are presented within a paradigm of preventive psychology. The history and current status of both fields are described, alternative competing models are presented, and the advantages in subscribing to a synthesis of behavioral approaches and prevention are discussed. Limitations in the traditional medical model, which historically has guided the use of behavior modification with individuals and groups, are described. Behavioral interventions that take a preventive stance are categorized along a number of dimensions: behavioral technology used (i.e., operant and classical conditioning, modeling, cognitive approaches); type of intervention (high-risk, prevent onset of behavior, competency enhancement, transitions); and developmental period (childhood, adolescence, adult, senior citizen). Research on behavioral interventions in the community is presented.

85. **Kelly, J.G., Snowden, L.R., & Munoz, R.F. (1977). Social and community interventions. *Annual Review of Psychology, 28*, 323–361.**

Eight topics are discussed in this review of research on social and community interventions (SCI): patterns of helping service delivery; diverse cultures; primary prevention; social environment; social change and public policy; theories about SCI; methods for community research; and education and training for community service. It is argued that community services will evolve into SCI as they integrate persons into their sociocultural milieu. Members at the bottom of the economic ladder should actively participate in planning and implementing services. The relationship between social context and the person is emerging as a priority topic for the design of SCI; there is evidence that the social environment is a key influence for long-lasting SCI impact. Working on social change requires a multidisciplinary perspective: a critical attitude and a commitment to aid in forming public policy are needed. Precise SCI theory construction requires a close coordination with ongoing social and community processes. The character of social community problems demands methodological resourcefulness and flexibility. The variety and ability of professionals and nonprofessionals can provide new resources as new roles for SCI develop. Goals for SCI are outlined and a list of information sources on SCI are presented.

86. Kessler, M., & Albee, G.W. (1975). Primary prevention. *Annual Review of Psychology, 26*, 557–591.

Literature dealing with primary prevention of mental disorders is reviewed, beginning with definitions. Consideration is then given to models of disturbance, epidemiology and ecology, primary prevention programs such as general education programs of the mental hygiene movement, and the use of preventive techniques in social planning. Difficulties for scientific study inherent in the field are examined and an attempt is made to clarify research problems. It is concluded that primary prevention in many areas may require social and political changes to improve the quality of life.

87. Lemkau, P.V. (1965). Mental health services. In P.E. Sartwell (Ed.), *Maxcy-Rosenau preventive medicine and public health* (9th Ed., pp. 586–628). USA: Meredith.

This broad and comprehensive chapter covers a wide variety of aspects of mental health services, including the classification of mental illness, the size of the mental illness problem nationally, and a description of varied programs developed for persons in the mental health system. A significant portion of the chapter, however, is devoted to the prevention of psychiatric illnesses and the promotion of mental health. Included here are such topics as prevention of illness related to emotional and social stress through education of the public about a variety of mental health issues. The notion of developmental crisis is then discussed, and a variety of prevention programs relevant to those crises are cited, including programs of prenatal care, the management of pregnancy, and prematurity. School health programs are discussed as examples of preventive programs as children grow older, as are efforts at sex education. Examples throughout the life cycle follow. The chapter concludes with a comprehensive discussion of the administration of mental health services.

88. Lemkau, P.V. (1973). Mental health services. In P.E. Sartwell (Ed.), *Maxcy-Rosenau preventive medicine and public health* (10th ed., pp. 547–590). New York: Appleton-Century-Crofts.

In this book chapter the author discusses mental health services as a part of health programs under three general headings: (1) mental health services, (2) epidemiology of mental illnesses, and (3) administration of mental health services. Following this is a general discussion of prevention of psychiatric illnesses and promotion of mental health. The author reviews prevention activities as they relate to: (1) stress, (2) pregnancy and prenatal care, (3) well-baby clinics, (4) school health programs, (5) prevention in work settings, and (6) prevention with the elderly.

89. **Munoz, R.F. (1976). The primary prevention of psychological problems.** ***Community Mental Health Review, 1,*** 5-12.

Preliminary studies of primary prevention of psychological disorders are reviewed, approaches to primary prevention are classified, and the role of the community mental health center (CMHC) with respect to primary prevention is discussed. Primary prevention is defined as those efforts attempting to reduce the incidents of new cases of mental disorder or disability in a population. Some recent efforts have included: (1) a childrearing education service; (2) interpersonal cognitive problem-solving training for young children; (3) special education programs for infants born to low IQ, low income mothers coupled with vocational, homemaking, and childrearing training for the mothers; and (4) a heart disease prevention program utilizing mass media advertising and/or behavioral training. Controversy surrounding primary prevention in community mental health is examined. It is suggested that primary prevention efforts might be disseminated through the CMHC once they have been tested for effectiveness. It is concluded that a suitable goal for primary prevention efforts is the prevention of demoralization.

90. **Munoz, R.F., & Kelly, J.G. (1975).** ***The prevention of mental disorders.*** **Homewood, IL: Learning Systems.**

A brief history of the mental health field is presented, including some emphasis on the community mental health movement. A rationale for preventive services is proposed, and the importance and general methods of primary prevention are described. Stressful life conditions and events are identified as the primary focus of prevention services. The human life cycle is presented and examined as a generally regular series of developmental stresses and crises. Several distinct periods are denoted, and preventive techniques are proposed that concentrate on facilitating the transition through these crises by promoting the mastery of new developmental skills. Depression, suicide, alcoholism, and schizophrenia are each examined theoretically, and key stress points in the etiology of these disorders are identified and specific preventive techniques to ameliorate the stressful circumstances are suggested. The important influence of the school system on the lives of all people in this country is recognized, and consequently its potential as a primary prevention instrument is discussed. Some methods to enhance the efficiency and effectiveness of the school system in the prevention of mental disorders are proposed. Finally, a general framework of interlocking local, State, and Federal resources coupled with citizen groups and associations that could improve the promotion of mental health services is presented.

91. **Murphy, L.B., & Frank, C. (1979). Prevention: The clinical psychologist. *Annual Review of Psychology, 30,* 173–207.**

This article reviews research and theory on the advocacy role of the clinical psychologist; types of prevention in work, crime, and other at-risk settings; national proposals for prevention; types of local prevention programs; and basic principles of prevention planning. ©APA.

92. **Perlmutter, F.D. (1979). Primary prevention in mental health services: The U.S.A. experience. *Israel Annals of Psychiatry and Related Disciplines, 17,* 45–57.**

Primary prevention activities of community mental health centers in the United States are described and their applicability to Israeli society are discussed. Three types of activity within primary prevention are described: (1) crisis intervention (providing anticipatory counseling to groups of people to promote adaptation to life crises), (2) institutional change (making social institutions, such as the educational system, more responsive to people's mental health needs), and (3) social action (analysis of social and environmental conditions and advocacy of improvement). Evidence is provided that primary prevention activities, which were initially formulated at the Federal level, are regarded as much less feasible than are secondary and tertiary prevention programs by local community mental health centers. Other data reveal that nearly two-thirds of primary prevention programs consist of indirect services provided to institutions, and about one-third comprise direct services to populations at risk. Although the applicability of some American primary prevention programs to Israeli society is questioned, the author concludes that Israel is in a unique position to pioneer programs in primary prevention.

93. **Porterfield, J.D. (1957). The place of primary prevention services. In *Programs for community mental health* (pp. 184–195). New York: Milbank Memorial Fund.**

The author begins with a general discussion of prevention and the perspectives of other speakers at the conference reported in the larger book. He then devotes attention to three general methods of preventing personality disorder: those methods producing changes in (1) the physical environment, (2) the psychological environment, and (3) the person. Changes in the physical environment include improved design and construction of housing, dealing with lead poisoning, and efforts to provide nutritious food for people. Changes in the psychological environment include changing attitudes of drivers to prevent accidents and safety education in the school curriculum toward that same end. Changes in the person physically include an emphasis on health maintenance and optimal nutritional status.

94. Rae-Grant, Q. & Rae-Grant, N.I. (1970). Preventive care. In H. Grunebaum (Ed.), *The practice of community mental health* (pp. 247–276). Boston: Little, Brown, & Company.

The authors first discuss the concept of prevention and the common misperceptions regarding its implementation with community mental health centers. The authors list the contributions that professional mental health workers have made to prevention and provide guidelines for the development of prevention of programs. Potential opportunities for preventive intervention are then discussed under four headings: (1) natural developmental crises, (2) social crises, (3) stress created by institutions, and (4) community-wide educational and organizational programming. The authors conclude by stating that this country's social and mental health needs can only be met by total community involvement in prevention programs and that knowledge of how to develop and implement these programs currently exists.

95. Raphael, B. (1980). Primary prevention: Fact or fiction. *Australia & New Zealand Journal of Psychiatry, 14*, 163–174.

The article reviews studies oriented to the primary prevention of psychiatric disorder. Difficulties in this field are noted, including current etiological concepts, outcome measures, techniques and processes, methodological problems, humanitarian and ethical issues, and the role of social processes. These include projects directed toward parenting processes, vulnerable children, crisis intervention, and psychosomatic variables. Resistances to preventive work are outlined. The author concludes that much work in this field represents a "call" for prevention; that diffuse interventions for diffuse population groups to achieve diffuse outcomes may not lead to demonstrable effects in prevention. Specific interventions directed toward high-risk populations to achieve specific preventive goals have shown that primary prevention may be accomplished in some areas.

96. **Rasmussen, S. (1976). Preventive programs and strategies. In R.G. Hirschowitz, & B. Levy (Eds.), *The changing mental health scene* (pp. 219–228). New York: Spectrum.**

This chapter describes preventive programs and strategies. Prevention is defined as trying to change situations that contribute to the development of mental and emotional illnesses, and working directly with people who are at high risk of developing mental and emotional disorders if nothing is done. Preventive programs are considered an objective and priority by most health agencies; programs are varied and innovative; and, most frequently, programs are interagency collaborative efforts. Sound evaluation of preventive programs is developing. Although prevention is recognized as "everyone's business," lack of funding hampers program development. Suggested strategies to develop prevention programs include: obtain sanction for prevention; plan preventive programs on the basis of identified needs; define problems; initiate interagency collaborative efforts to implement preventive programs; participate actively in preventive programs spearheaded by other human service agencies; include a rigorous evaluative component in every preventive program; advocate preventive programs that are politically popular, safe, and sound; support efforts to make prevention profitable; and work toward an ideology that embraces the notion that people are healthy, whole, good, and social.

97. **Reinherz, H. (1980). Primary prevention of emotional disorders of children: Mirage or reality. *Journal of Prevention, 1*, 4–14.**

The feasibility of large-scale programs of primary prevention of emotional disorders of children is considered. Two major obstacles toward the advancement of primary prevention programs specifically designed for children are definitional problems and translation of common definitions into viable programs. Three major types of existing primary preventions programs are described with a number of examples presented. The first two typologies, promoting and enhancing competency and creating environmental and systems change, meet the definition criteria. The third--and most controversial--type, reducing disorders by identifying populations at risk, is placed on the boundary between primary and secondary prevention. Specific recommendations for future primary prevention programs are discussed.

98. **Roberts, C.A. Preventive psychiatry. (1968). In I. Gregory (Ed.), *Fundamentals of psychiatry* (pp. 306–327). Philadelphia: W.B. Saunders.**

This book chapter discusses the concepts of primary, secondary, and tertiary prevention. It argues for attempts at prevention along with basic research to better identify the signs of mental disorders. The author states that once the etiology of a mental disorder is known, primary prevention is no longer within the sphere of the psychiatrist but becomes the responsibility of public health personnel. The author reviews types of poisons, infections, genetic and nutritional diseases, and other physical abnormalities that can produce mental disorders. The importance of the community structure in influencing the mental health of community residents and the role that government and society should take in lessening sociocultural disintegration are discussed. Finally, the author advocates the need for an improvement in the general living conditions of individuals and suggests the important role schools, churches, and community organizations can play in social action designed to promote mental health and prevent mental disorders.

99. **Sanders, D., & Gruenberg, E.M. (1965). Mental health. In H.R. Leavell, & E. B. Clark (Eds.), *Preventive medicine for the doctor in his community* (pp. 1–29). New York: McGraw-Hill.**

The author discusses the statistics of mental illness and the increasing concern among the general public and medical professionals about mental illness and mental health. The authors point out that research into the etiological factors behind mental disorders is greatly needed, and they highlight some of the assumed variables that may contribute to psychopathology. Common presenting syndromes (depressive, severe anxiety, chronic tension, paranoid, manic, confusional, and mental retardation syndromes) are discussed and the authors state that there are at present no primary prevention techniques for these syndromes. The levels of prevention are then presented along with descriptive examples. The last section of the chapter is devoted to a review of the organization of community services, including those elements of the services that are geared to reducing disability and providing early diagnosis and prompt treatment.

100. **Spaulding, J., & Balch, P. (1983). A brief history of primary prevention in the twentieth century: 1908–1980. *American Journal of Community Psychology, 11*, 59–80.**

While primary prevention is a much talked about and debated topic in contemporary psychology, it has a considerable history.

This paper critically traces primary prevention, philosophy, and practice in the 20th century. Beginning with the mental hygiene movement (1908-60), the paper progresses to examine the child guidance movement (1920-55), the eugenics movement (1860-1955), the initial era of Federal involvement (1930s, 1940s) as well as significant research, events, and legislation in the decades between 1950 and 1980. The paper concludes with a synopsis of the major themes revealed by the review and suggestions for future efforts in prevention. (Author abstract) ©Plenum Publishing Corp.

101. **Tableman, B. (1981). Overview of programs to prevent mental health problems of children. *Public Health Reports, 96*, 38–44.**

Directions that have been explored in the mental health and substance abuse fields to support the normal, healthy development of children are reviewed with emphasis on those dealing with young people at-risk for emotional, cognitive, or behavioral disorder. These programs focus on interventions in populations with high rates of deviant behavior or with socioeconomic characteristics that make them especially vulnerable. Specific groups include infants and children experiencing separation, conflict between parents, multiple hospitalizaitons, loss of parents through death or divorce, offspring of disordered parents, and young people experiencing difficulty in school. It is argued that these children are not subject to a single critical event but are likely to experience continuing stress and deprivation. Programs sponsored by the Alcohol, Drug Abuse, and Mental Health Administration, as well as those implemented by other local and State agencies, are described and suggestions are made for improvements in services.

102. **Tableman, B. (1982). Prevention interventions for children and adults. In E. Arnowitz (Ed.), *Prevention strategies for mental health* (pp. 57–80). New York: Prodist.**

The author uses D. F. Rick's Continuum of Functional/Dysfunctional Behavior to set a conceptual framework for prevention initiatives. The author states that prevention rests on the premise that the behaviors and perceptions we use in confronting life situations are learned; thus, competency is one's learned ability to cope with stress, and prevention rests on the premise that the social environment can facilitate our adaptation to confronting life crises and stress. Then the author explains how children and adults can be encouraged to learn positive coping methods and how they might be assisted in moving through the adaptation process. The author describes three categories of preventive intervention: (1) health promotion, (2) accommodation to life crises, and (3) intervention around multiple chronically debilitating developmental circumstances. The author offers a classification of four categories of methodological approaches for the development of competence: (1) self-help and support efforts, (2) competency or problem-solving training, (3) behavioral contingencies, and (4) individualized intervention. The author presents many programs for prevention initiatives with children and adults. Descriptions of each of these programs, including title, author, applicable population, purpose, content, implementation, and an evaluation, are provided in an appendix to this article. In conclusion, the author states five operant characteristics that make up a good prevention program. Finally, the statement is made that there is a need to go beyond individualized programs to programs organized to be implemented systematically in a prevention-minded community.

103. **Valletutti, P.J., & Christoplos, F. (1979). *Preventing physical and mental disabilities: Multidisciplinary approaches*. Baltimore, MD: University Park Press.**

Multidisciplinary approaches to preventing physical and mental disabilities are examined from the perspective of 20 different therapeutic disciplines. Topics include: (1) the evolution of preventive concepts in social work, including direct services to target populations during times of developmental crisis, and the necessity for professionals to respect and support extended family systems and the natural helping networks of communities; (2) genetic counseling, including the complex personal or ethical issues involved; (3) nutrition in the prevention of emotional and physical disorders and the importance of maternal health during pregnancy; (4) art and music therapy; (5) a biopsychosocial model for determining the varying susceptibility to preventive measures of healthy and dysfunctional families; (6) a working group in counseling for adult mental health; and (7) the mental health role of the criminal justice system.

104. West Michigan Health Systems Agency (1980). ***Mental health primary prevention for children: A study of the literature***. (NTIS No. HRP-0902550/3). Springfield, VA: N.T.I.S.

The literature on child-oriented mental health prevention programs is reviewed, along with information from interviews with professionals in the field, in order to devise a theoretical framework from which to approach mental health prevention, especially the emerging activity of primary prevention. Programs in health care settings emphasize the mother-infant relationship and the special problems of adolescents. Promoting healthy child-adult relationships through role modeling is the key to prevention in the family setting. Programs in the school setting prepare the teacher to act as a facilitator for the promotion of sound mental health among children. Due to a multitude of barriers including public assistance, the low status of prevention professionals, and difficulty in providing effective programming, community mental health agencies have traditionally avoided prevention programming for children. (Author abstract modified)

105. **Yule, W. (1977). The potential of behavioral treatment in preventing later childhood difficulties. *Behavioral Analysis & Modification*, *2*, 19–32.**

This article examines the concepts of primary, secondary, and tertiary prevention and determines their utility when applied to children's behavior disorders. Several interventions that may be useful in treating such disorders are reviewed, including parent training, classroom interventions, and social skills training. Methodological problems make it premature to conclude that primary prevention is now a reality. Several procedures are suggested for assessing programs designed to prevent childhood behavior disorders. ©APA.

106. **Zolik, E.S. (1981) Primary prevention. In W.H. Silverman (Ed.), *Community mental health: A sourcebook for professionals and advisory board members* (pp. 172–195). USA: Praeger.**

The author first defines the three levels of prevention and then discusses the role and importance of epidemiology in primary prevention. A conceptual discussion of the difficulties in understanding the causality of mental disorders is given, along with a discussion of crisis theory as it relates to the development of psychopathology and the prevention of disorders. A new model for prevention based on the recommendations of the 1978 President's Commission on Mental Health is given. Such an approach is based on the idea of identifying stressful events and crises that have adverse consequences for certain individuals and then monitoring preventive interventions to reduce the incidence of stressful life events or increase the coping skills necessary to manage such events. A brief review of programs and approaches to prevention is presented. Such approaches are classified as either person-oriented or social systems-oriented. The C & E programs of CMHCs are discussed concerning their roles in prevention activities. Finally, certain practical and political barriers confronting primary prevention of psychopathology are reviewed and further pursuit of primary prevention activities is advocated.

See also: 5, 14, 15, 24, 33, 37, 52, 110, 114, 115, 188, 195, 197, 214, 236, 245, 267, 269, 283, 292, 355, 478, 670, 680, 815, 819, 905, 910, 981.

D. Primary Prevention and Epidemiology

Articles in this section concern themselves with the epidemiology of mental disorders as it relates to the primary prevention of psychopathology.

107. **Bloom, B.L. (1977). An epidemiological approach to program development for primary prevention. In D.C. Klein, & S.E. Goldston (Eds.), *Primary Prevention: An idea whose time has come* (pp. 83–84). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

Major findings of an epidemiological study of mental health services delivery in a single community in 1960 and 1970 are outlined. Findings included: (1) Inpatient admission rates increased tremendously between 1960 and 1970. (2) Social class is not dramatically related to admission rates while neighborhood social disequilibrium is. (3) A dramatic increase in Spanish surnamed inpatients occurred, and these were overrepresented in the patient population. (4) Economic conditions continue to play a major role in the locus of psychiatric care. (5) Length of hospitalizations has decreased and continues to decrease. (6) Twenty-five percent of patients are readmitted within 2 years and there is a tendency to switch to an alternative type (public versus private) of facility. (7) Marital disruption is a powerful possible emotional stressor. Implications of findings for preventive intervention are also stressed.

108. **Dohrenwend, B.P. (1977). The epidemiology of mental illness: Psychiatric epidemiology as a knowledge base for primary prevention in community psychiatry and community mental health. In G. Seiban (Ed.), *New trends of psychiatry in the community* (pp. 53–67). Cambridge, MA: Ballinger.**

The author first briefly reviews the various prevalence rates of psychiatric disorders with no known organic bases. Contrasting methodologies of various epidemiological studies have made it difficult to determine what the "true" prevalence rates are. A clearer picture has emerged as to differences in prevalence rates on the basis of sex, social class, and urban versus rural settings. The most persuasive evidence for environmentally induced stress as important in the etiology of psychiatric disorders has come from studies of individuals and groups exposed to extraordinary disasters, especially the disaster of war. The author believes that the research area of stressful life events has the best chance of providing a viable knowledge base for preventive action when a socio-environmental orientation to etiology is taken.

109. Emerson, H. (1969). Epidemiology as a possible resource in preventing mental disease. In F.R. Moulton (Ed.), *Mental Health* (pp. 9–13). USA: American Association for the Advancement of Science.

This article discusses the potential usefulness of epidemiological methods as a basis for understanding mental disease and its origins. This knowledge may then serve as a basis for intervention. The author stresses how little relevant work in epidemiology has been undertaken, and that the numerous clinical accounts of individuals "lack the basic facts required for epidemiological analysis." Caution is advocated in promoting various social, economic, and educational correctives in the absence of knowledge of etiology.

110. Graham, P.J. (1977). *Epidemiological approaches in child psychiatry*. New York: Academic Press.

This volume presents papers by participants in a symposium on epidemiological studies in the child psychiatric field. Contributors came from many different countries and their reports represent work at various stages of completion. Major sections in the book include methodology, early parenting, the pre-school child, middle childhood, adolescents, handicapped children, and special approaches to research, intervention, and prevention. Content areas include child abuse, behavioral screening of children, rates of disorder in urban and rural populations, and the methodology of epidemiolgical survey research. The importance of epidemiological knowledge in the planning of preventive intervention is stressed.

111. Morris, J.N. (1982). Epidemiology and prevention. *Milbank Memorial Fund Quarterly/Health and Society, 60*, 1–16.

In the opening address given at the ninth scientific meeting of the International Epidemiological Association in 1981, the author discusses the important partnership between epidemiology and preventive medicine. The importance of the environment and lifestyle in preventing disorders and promoting health is emphasized. The author suggests that epidemiologists should be prepared to investigate and attempt to prevent psychological and mental problems resulting from increased technology as we approach the year 2000.

112. **Pasamanick, B., & Knobloch, H. (1961). Epidemiologic studies on the complications of pregnancy and the birth process. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 74–94). New York: Basic Books.**

A number of studies conducted by the authors demonstrating the existence of precursors of neuropsychiatric disorders are summarized. Using large sample sizes and naturalistic epidemiologic investigation procedures, the authors found several significant associations between prenatal factors and birth complications. Specifically, mental deficiency was found to be related to very young and older mothers. Reading disabilities, hyperactivity, and disorganization were also related to early trauma. Extensive evidence for increased abnormalities among infants conceived in the summer months was also cited. In general, it was found that all complications were at least partially socioeconomically determined, with much greater risk occurring at the lower socioeconomic levels.

113. **Susser, M. (1981). The epidemiology of life stress. *Psychological Medicine, 11*, 1–8.**

Areas of concern to epidemiologists in research and prevention of life stresses are considered. The author addresses the following topics: instruments, design, analysis and hypothesis testing, and control and prevention of pathology. Additionally, the notion of the triad agent/host/environment is considered along with the need, in analyzing the problems of health disorders and in constructing research designs, to segregate these three interrelated elements. The example of smoking, a harmful habit that has been reduced at a societal level by social action, is noted.

See also: 64, 66, 71, 75, 83, 87, 106, 623, 672.

E. Primary Prevention in Other Countries

This section presents articles that overview prevention activities in countries other than the United States.

114. **Clarke, A.M., & Viney, L.L. (1979). The primary prevention of illness: A psychological perspective. *Australian Psychologist, 14*, 7–20.**

Health care systems in Australia focus primarily on the treatment of existing illness. Much of this illness is known to be psychosocial in origin. Primary intervention, by psychologists among others, aimed at attempting to prevent such ill health therefore seems an appropriate addition to the already existing systems. The concept of primary prevention is explored with a focus on the development of more competent coping both by people with ongoing difficulties and those who may experience difficult situations. Why primary prevention is not being practiced more extensively is examined. Answers discussed include the lack of immediate rewards for professionals; its low visibility, which hinders adequate government funding; and the lack of descriptive research results on which to base it. Examples of primary prevention from North America and Australia are discussed. Implications of this approach for the research and practice of Australian psychologists are considered. © APA.

115. **Hartman, L.M. (1980). Primary prevention: The Canadian scene. *Canada's Mental Health, 28,* 11-12.**

The state of primary prevention in Canada was investigated via survey of relevant activities engaged in by district and provincial organizations. Primary prevention was defined as that proactive enterprise designed to develop adaptive strengths and coping resources in total populations, especially groups at high-risk, through education and social engineering. Program examples include self-help groups, planning for retirement, bereavement counseling, and educating for mental health. Untapped areas involve programs to improve maternal-infant interaction; education for marriage and parenthood; programs to help children adjust to hospitalization and surgery; activities highlighting the relationships between nutrition and mental health; and attacks on societal and individual stress produced by poverty, racial inequality, sexism, and the physical environment.

116. **Ho, D.Y.F. (1974). Prevention and treatment of mental illness in the People's Republic of China. *American Journal of Orthopsychiatry, 44,* 620-636.**

This paper traces the development of psychiatry in the People's Republic of China--with special reference to the social aspects of treatment and prevention--and delineates the salient features of the Chinese approach. Three discernible phases are described: (1) rapid growth from 1949 to the Great Leap Forward (1958) under the influence of the Soviet Union; (2) radical reforms in patient management during the Great Leap Forward, including a lessening of patient restrictions and a more active effort to "normalize" rather than "institutionalize" the patient experience; and (3) developments since the Great Cultural Revolution, which include a more comprehensive and integrated approach to patient care with increased use of community resources. The current Chinese approach to the problem of mental illness includes a variety of emphases, including a belief in the environmental nature of mental illness and, hence, its curability, and an emphasis on prevention, where "it is claimed that the superiority of the socialist system provides the best preventive against mental illness." Implications of the Chinese approach for mental health workers in other countries are discussed.

117. Singh, M.V. (1980). Community mental health and child guidance centre. *Child Psychiatry Quarterly, 13*, 94–97.

This article describes current attempts in India to improve mental health services for children. Child guidance clinics are discussed in light of three types of preventive services: primary, which are within the framework of a variety of nonpsychiatric areas such as education and social and medical agencies; secondary, which deal with psychological testing to detect problems in childhood; and tertiary, which are directed at changing the familial, social, and school atmosphere of the disturbed child to allow maximum development of potential. © APA.

See also: 92, 95, 191, 198, 302, 315, 356, 395, 432, 557, 582, 605, 673, 681, 705, 717.

II. Debates and Issues Concerning Primary Prevention

A. Articles Advocating Primary Prevention

Articles in this section state the need for primary prevention and advocate that efforts be made to prevent mental illness and promote mental health. In contrast to the next section, these articles take a positive stance toward primary prevention.

118. Albee, G.W. (1982). Primary prevention: Insights for rehabilitation psychology. *Rehabilitation Psychology, 27*, 13–22.

The author suggests that the gap between the number of persons suffering from mental disorders and the number of professionals available to help them is so large it may never be bridged. This situation demands intensified efforts at primary prevention of disturbance and disability. Proponents of this position encounter opposition from those who benefit from the status quo dominated by the medical model. However, the field appears to be moving inexorably toward a new model of health and illness, a model that demands social change and personal responsibility for health and emphasizes the importance of support systems and networks. ©APA.

119. **Albee, G.W. (1982). Preventing psychopathology and promoting human potential.** ***American Psychologist, 37*****, 1043–1050.**

Primary prevention of mental and emotional disturbances emphasizes the reduction of unnecessary stress, including powerlessness, and the enhancement of social competence, self-esteem, and support networks. This approach holds that it is possible to reduce the incidence of mental and emotional disorders. It argues that one-to-one psychotherapy is a hopeless approach because of the unbridgeable gap between the large numbers in need and the small numbers of helpers. Further, it holds that chemical or organic treatment is a reactionary form of symptomatic relief that is part of a long history of oppression and failure. Support for a primary prevention alternative derives from: (a) the successful application of public health methods in promoting population health; (b) a growing body of research literature that demonstrates the role of poverty, meaningless work, unemployment, racism, and sexism in producing psychopathology; and (c) the effectiveness of programs promoting social competence, self-esteem, and social support networks in reducing psychopathology. Opposition to primary prevention comes from: (a) those who argue for a defect model explanation of psychopathology; (b) those whose personal commitment is to one-to-one therapy; and (c) those Calvinists who believe that neither individual human beings nor society is perfectible because of the stigma of original sin. (Author abstract) ©APA.

120. **Beattie, N.R. (1972). Community mental health: The preventive aspects.** ***Community Health, 4*****, 2–7.**

The author begins by asserting that health, including emotional health, is the birthright of all. The challenge of much of the disease that causes human misery is not its treatment but its prevention. Freud, Jung, and Adler are cited as persons whose contributions to the understanding of individuals give us tools to work in the area of prevention through the education of parents, teachers, and those in the managerial world. Emphasis in this education is placed on identifying the influence of the hazards of the social environment, and the family is cited as the critical place for such educational effort to begin.

121. **Becker, A., Wylan, L., & McCourt, W. (1971). Primary prevention––whose responsibility?** ***American Journal of Psychiatry, 128*****, 412–416.**

The authors state that community mental health centers must make a commitment to develop primary prevention services for high-risk groups in their catchment areas. Boston State Hospital, in collaboration with its community and other human service agen–

cies, has developed a program focused on the needs of children. It includes a school program, community center, family intervention unit, children's developmental workshop, court program, and a special high-risk-group program. The critical need for a new alliance of human service providers is stressed.

122. **Beers, C.W. (1956). *A mind that found itself*. Garden City, NJ: Doubleday and Company. (Original work published 1908).**

This autobiography is an account of the author's 3-year episode of chronic psychosis. It describes in detail his experience of a psychotic mind and the institutional treatment he received. His self-stated purpose for writing this book was to start a campaign for improved care and treatment of the sufferers of mental illness, as well as for the prevention of mental illness. The book is considered the main force behind the initiation of the Mental Hygiene Movement (1908-1960), established to, among other things, conserve mental health, prevent nervous and mental disorders and defects, and raise the quality of care for those suffering from the disorders and defects. In addition to the autobiography, the book includes an account of the events leading to the development of the National Committee for Mental Hygiene, as well as supplementary chapters written by Dr. C. E. A. Winslow, Dr. L. E. Woodward, and Dr. N. Ridenour, each reporting on the developments and activities of the Mental Hygiene Movement for the periods of 1908-33, 1934-47, and 1948-52, respectively.

123. **Bloom, B.L. (1981). The logic and urgency of primary prevention. *Hospital and Community Psychiatry, 32*, 839-843.**

Widespread prevalence of emotional disorders dictates allocation of more funds for development of primary prevention programs. For years investigators have successfully used the specific disease prevention paradigm to control infectious and nutritional diseases. To prevent psychiatric disorders, however, investigators are now including a general disease prevention paradigm that seeks etiological factors among a variety of stressful life events as well as among biological, psychological, and sociological factors that differentially predispose individuals to emotional disorders. An effective primary prevention campaign is proposed that will require a national policy for the enhancement of mental health and perhaps the establishment of an agency concerned solely with primary prevention. (Author abstract modified)

124. **Carver, J. (1977). Community based programs for preventing mental illness prevention: Begin at the beginning.** ***Mental Hygiene, 60,*** **7–10.**

The concept of primary prevention of mental illness is discussed, positing that because mental health professionals and agencies have traditionally defined their area of responsibility as that of treating emotional pathology, 93 percent of the population who need services to prevent mental illness are going unserved. Further, if society concentrated on developing competent, adaptable human beings by preparing children for the world by optimizing their coping skills, personal competencies, and ability to deal with their emotions and relationships with others, mental illness could be prevented. It is suggested that one approach toward prevention of emotional disorders is through decentralizing mental health skills and by adapting current systems to the optimization of human resources. An example of the systems change would be for schools to recognize their role as the central mental health agency in the lives of children. Also, the need for the cooperative, indirect services of clergymen, physicians, teachers, and parents is encouraged. It is postulated that, related to historical reasons for insufficient consultation and education services, training for mental health professionals usually lacks the skills necessary for delivering these community services. Financial support for the training and staffing of such services is emphasized as crucial. It is concluded that the community health center holds an available reservoir of skills for primary prevention.

125. **Eisenberg, L. (1962). Preventive psychiatry—If not now, when?** ***American Journal of Orthopsychiatry, 32,*** **781–793.**

In criticizing the Joint Commission Report "Action for Mental Health" as conceptually restrictive, the author proposes supplementary means by which the inefficacy of current preventive practice in mental illness can be eradicated. The goals of prevention and devising specific methods of preventing particular disorders are exemplified through a discussion of the deprivation syndrome. Primary prevention of certain disorders is posited to be possible, subject to the will of the professional and citizen alike. The author cites family planning, health care, housing, unemployment compensation, job training, casework services, substitute homes, enrichment facilities, and other social services as means to ameliorate problems. The responsibility belongs to the mental health professional and training institutions to promote experience and interest in community and public hospital psychiatry, the development of increased research competence, and a more avid concern for the political and social precursors of those social ills.

126. **Evang, K. (1974). Mental health—public health. *World Health*, October, 8-11.**

Public health action is discussed in terms of preserving physical and mental health. Pathogenic agents and preventive measures in mental illness are discussed according to age group. It is suggested that all disease, infirmity, and injury include a psychosocial component. Mental health is "public health" in the sense that society has an overriding responsibility to include in its general system of health services measures to prevent and cure mental disease and to rehabilitate those on the road to recovery.

127. **Foley, A.R., & Gorham, P. (1973). Toward a new philosophy of care: Perspectives on prevention. *Community Mental Health Journal, 9*, 99-107.**

Because the provision of mental health services follows a model of supply and demand, the treatment of symptoms receives higher priority than does the prevention of disorder. Increasing the extent of present services will do little to meet the increasing needs of psychiatric patients. What is required is a shift of emphasis to primary prevention, which will require a redirection of priorities and a new philosophy of care committed to primary prevention. Prevention is conceptualized as a response to either "existing or anticipated societal difficulties, to attempts to resolve them, and thus to planning properly for the future." Plans for prevention should be specific with respect to objectives, means, and programs. It is also necessary to understand and learn to use the political process to gain public support and government funding for programs aimed at prevention. Of great importance in the development of primary prevention is the commitment of mental health professionals to this approach. An integrated service network should include: (1) all existing service agencies to prevent duplication; (2) community groups to ascertain problems; (3) representatives of the mass communication industries, the utilization of which will maximize effectiveness; and (4) a coordinating and planning structure to establish immediate and long-term policy.

128. **Joint Commission on Mental Health of Children (1973). *The mental health of children*. New York: Harper & Row.**

The mental health needs of children are examined in terms of services, research, and manpower. A range of research is outlined from individual child pathology and therapy to broad issues concerning the influence of sociocultural factors on the mental health and mental illness of children. Emphasis is on the need to explore broad social influences, such as poverty, ghetto life, and racism, as well as migrant families, the families of suburbia, and the children of Appalachia. There is a strong concern for research in prevention, with a list included of possible areas for intervention research. Services examined include programs concerned with housing, employment, income maintenance, education, family stability, transportation, and day care. Both preventive and interventive programs are advocated. Gross inadequacies are noted among present programs that can be immediately available to children and families. The need for more professionals and paraprofessionals is stressed.

129. Leavell, H.R. (1961). Prevention: Our common purpose. *Journal of the Mississippi State Medical Association, 2,* 143–148.

The thesis of this paper is that prevention activities represent an opportunity for collaboration between those interested in public health and private practitioners of medicine. The author builds on Dubos' plea to understand the many effects of environments on living things, and asserts that both health problems--including mental health--and the multiplicity of agencies that have developed to deal with these problems are becoming increasingly complex and interdependent. He differentiates between being in private practice and being a "physician to the community," yet views the two roles as potentially complementary in fighting the common enemy of disease. The importance of prevention is stressed and the difficulty of attracting doctors to public health as opposed to private practitioner roles is discussed.

130. Menninger, R.W. (1977). The critical need for prevention. *Menninger Perspective, 8,* 15–25.

The need for new concepts and programs that seek to prevent mental illness and the debilitating effects of poorly managed stress is discussed in light of the impossibility of providing adequate treatment for all the people who need it. It is noted that this requires the recognition by medicine and psychiatry that prevention goes beyond treatment, and demands that the professional disciplines be concerned with the reduction of emotional stress, the improvement of psychological competence, and the promotion of health and well-being. It is concluded that the person must be recaptured as the focus of medicine and psychiatry, rather than the disease, the psyche, or the psychosis.

131. Rae-Grant, N.I. (1972). Longevity, mobility, and spare parts: The future imperfect and human service delivery. *American Journal of Orthopsychiatry, 42,* 835–846.

The author notes that mental health resources are currently overwhelmed and the rate of change in society is such that the gap between needs and resources is liable to increase, even with a stabilized population. Emphasis must be placed on the underpinnings of a mental health system that pays attention to the sociological and educational needs of the individual, as well as to the more specific therapeutic provision for defined syndromes and diagnostic categories. The author recommends an educational approach to promote social competence as one aspect of any prevention program, that therapy involve a task analysis and a more clearly focused approach, and that consideration be given to a future rather than a past orientation. ©APA.

132. Roberts, C.A. (1968). Clarence M. Hinks memorial lectures. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders* (pp. 5–66). Toronto: University of Toronto Press.

The author discusses the history and philosophy of attempts at prevention of psychiatric disorder. It is apparent that treatment alone can never adequately reduce the prevalence of psychopathology, and though our knowledge of etiology is limited, we must attempt to implement preventive methods, especially with children. Successful programs in this field demand substantial government support in concert with the assistance of voluntary community-based organizations. Without the commitment and understanding of the community at large, preventive measures will not flourish. Specialists from different disciplines must be trained to make their respective contributions, while administrators should be well trained in their duties. The various general services that should be supplied are discussed and include support in times of stress, prevention of maternal deprivation, improvement of childrearing practices, prenatal care, reduction of radiological exposure, genetic counseling, and prevention of social isolation. Of considerable importance are general measures in the area of social action, with the aim of reducing sociocultural disintegration.

133. Van Antwerp, M. (1970). Primary prevention: A challenge to mental health associations. *Mental Hygiene, 54*, 453–456.

This article examines some of the logical reasons why efforts at primary prevention should be attempted. The author argues that primary prevention needs to be attempted before it can be found effective or ineffective. The author believes that mental health associations and the National Associaton for Mental Health need to be advocates of prevention programs and policies.

See also: 18, 75, 81, 98, 158, 166, 169, 170, 172, 174, 177, 182, 188, 192, 193, 213, 216, 218, 251, 271, 283, 284, 511, 533, 828, 835, 837, 839.

B. Critiques and Cautions about Primary Prevention

Articles that criticize, point out limitations, or advocate caution and restraint in primary prevention efforts are included in this section. None of these articles suggest that the idea of primary prevention is not sensible, but concerns are raised about such issues as the knowledge base for preventive interventions, the diversion of funding from treatment to prevention, and the ways in which preventive interventions are being conceptualized.

134. **Arnhoff, F.N. (1975). Social consequences of policy toward mental illness. *Science, 188,* 1277–1281.**

Social consequences of public policies affecting delivery of mental health services are critically examined, with emphasis on the shift toward community treatment and maintenance and the emergence of preventive concepts directed toward modification of conditions assumed to underly mental illness. Evidence now exists to suggest that the actual cost benefits of community treatment are less than anticipated, and that the consequences of indiscriminate community treatment may produce greater psychological and social disturbance than it corrects. The impetus of the mental health movement to obtain resources for purposes explictly related to mental illness has become diffused to broader social goals, and the range and sequence of treatment modalities perceived as alternatives to hospitals have not been implemented. A systematic reevaluation of mental health policy is recommended to minimize long-term undesirable effects while meeting the specific needs of types of mental illness.

135. **Brill, N.Q. (1972). Preventive psychiatry in public health. *California Medicine, 116,* 67–70.**

The treatment method placing emphasis on current societal stresses that may contribute to maladjustment is assessed. This trend has two potential complications: (1) individual treatment of patients will deteriorate, and (2) expectations that mental and emotional illnesses will be eliminated when societal stresses are eliminated will be unfulfilled. So far, no clear relationships between socioeconomic status and mental illness have been demonstrated; mental disorders seem to exist in every social, economic, and racial group. While elimination of societal stresses is a worthy humanitarian goal, it is reasonable to question the reliance on such idealistic goals as the main thrust of a preventive psychiatry program. Interdisciplinary cooperation between professionals in all concerned fields offers the best approach to solving sociomedical and mental health problems. Such programs will open new career opportunities for psychiatrists as part of public health teams.

136. **Brill, N.Q. (1977). Preventive psychiatry. *Psychiatric Opinion, 14,* 30-34.**

The author argues that current theories that attribute mental illness to social stress and emphasize preventive social action may result in the deterioration of individual treatment of patients and in unrealistic expectations that mental and emotional illness will be eliminated. Instead, it is suggested that preventive psychiatry be concerned with the need to ensure proper rearing of children and with a renewal of values of sacrifice. ©APA.

137. **Burks, J., & Rubenstein, M. (1982). The differences between treatment and prevention in mental health. *Hospital & Community Psychiatry, 33,* 390.**

The thesis is presented that very little connection exists between prevention and treatment in mental illness. The only connection that does exist makes both prevention and treatment groups compete directly for funds and recognition. Psychiatrists are physicians whose primary purpose is to recognize and treat illness; their goal is to restore normality, which requires determination of the most immediate cause of the symptom. Preventionists are interested in the adverse effects of discrimination, poverty, and threats of war on health and individual development. If these differences in approach could be acknowledged, then the two groups could pursue their particular directions with mutual respect.

138. **Butollo, W.H. (1977). Comment to W. Yule, "The potential of behavioral treatment in preventing later childhood difficulties." *Behavioral Analysis & Modification, 2,* 33-38.**

This article suggests problems arising from Yule's conceptualizations of treatments to prevent child behavior disorders. These problems include terminology about prevention and its consequences, the heterogeneity of behavior problems and differential primary prevention, modeling as a preventive method, aims of preventive interventions, and criteria of success. ©APA.

139. **Cain, A.C. (1967). Opinion: Perils of prevention. *American Journal of Orthopsychiatry, 37,* 640-647.**

In discussing the use of the concept of prevention, the author discusses some "perils" of this process. These perils include the compartmentalization of preventive interventions and clinical interventions, in which the opportunites inherent in the clinical role are either overlooked or not acted on because of the paradigm of the clinician. In addition, it is important, in the rush to prevent, to differentiate those spheres where we know enough to engage in preventive work from those where we do not. The positive role of evaluation of preventive interventions is stressed, particularly in light of the tendency to view prevention as inherently valuable. Finally, if prevention as an idea is to have a significant future, it is important to attend to the side effects of prevention programs.

140. **Coleman, L. (1978). Problem kids and preventive medicine. *American Journal of Orthopsychiatry, 48,* 56–70.**

This paper maintains that the preventive medical model is inappropriate for dealing with childhood developmental disorders. The history of preventive medicine is traced briefly, and its adoption by the mental hygiene, child guidance, and community mental health movements is discussed. It is concluded that a program of screening, diagnosis, and treatment for poor children wil have negative consequences for those it is meant to serve. (Author abstract) ©American Orthopsychiatric Association.

141. **Cowen, E.L. (1977). Psychologists and primary prevention: Blowing the cover story. *American Journal of Community Psychology, 5,* 481–189.**

In this article, several suggestions for the advancement of primary prevention in mental health are discussed. There is a gap between abstract definitions of primary prevention and the concrete activities and programs cited to illustrate it. Primary prevention has been more of a rallying cry for psychologists than an approach for aiding people's adjustment and well-being. A research study is presented as evidence that primary prevention actually has no established identity to distinguish it from any other form of preventive care. It is concluded that the main reason for the paucity of concrete primary prevention programs is that psychologists have done little actual work in this area.

142. **Cumming, E. (1972). Primary prevention—more cost than benefit. In H. Gottesfeld (Ed.), *The critical issues of community mental health* (pp. 161–174). New York: Behavioral Publications.**

The author presents the argument that the effectivenss of popular primary prevention strategies (i.e., crisis intervention and consultation) of the major mental illnesses has not been tested. It is contended that these strategies remove needed manpower from the treatment of the mentally ill. The author supports the view that primary prevention through crisis intervention is in theory unnecessary in a stable society, and in an unstable one the usefulness of employing scarce resources for this purpose is confounded.

143. **Cumming, E. (1968). Unsolved problems of prevention. *Canada's Mental Health*, Supplement No. 56, 3–12.**

In a revised version of a talk given in 1962, the author discusses the successes and failures of the prevention of mental disorders. Most successes have come where the etiology of the disorder was known. Where the etiology has been unknown, strategies of prevention, including education for positive mental health and the learning of proper parenting skills, should be questioned as to their efficacy and scientific legitimacy. A major reason for the slow progress in dealing with mental illness is scientists' lack of sensitivity to the need for a multicausal theory of mental illness. The author alludes to the importance of one's social support system as instrumental in protecting the individual against mental illness.

144. **Glasscote, R.M. (1981). Talking sense about prevention. *Hospital & Community Psychiatry, 32*, 823.**

Sense and nonsense in professionals' attitudes and opinions about preventing mental illness are discussed. Mental health practitioners should realize that some mental illnesses can be prevented without question; others can be prevented in some cases if one tries; and others such as schizophrenia and sociopathy cannot be prevented until mental health technology is more developed. No great amount of money has been spent on prevention and therefore not much money has been wasted; there is, however, reason to believe that much of what has been spent was wasted in efforts to prevent the development of conditions that cannot at this point be prevented.

145. **Henderson, J. (1975). Object relations and a new social psychiatry: The illusion of primary prevention. *Bulletin of the Menninger Clinic, 39*, 233–245.**

The author advances the thesis that if community psychiatry is to survive as a concept, let alone as a specialty, its theoretical bases and practical methodology need to be strengthened; that social psychiatry as currently conceived is too feeble to offer much hope of rescue; but that the object relations viewpoint in social and community work may offer some help in understanding the sociopathology of civilization. The danger is that early commitment to psychiatric prevention may obstruct the development of generations of future psychiatrists and mental health professionals. The prevention idea may well prove premature, and society will be justly angry that psychiatrists have failed to carry out their primarily clinical mandate. ©APA.

146. **Ketterer, R.F., Bader, B.C., & Levy, M.R. (1980). Strategies and skills for promoting mental health. In R.H. Price, R.F. Ketterer, B.C. Bader, and J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 263–283). Beverly Hills: Sage**

Despite the attention recently given to prevention in mental health, relatively little is known about prevention strategies or about the knowledge and skills required by prevention practitioners. In part, this problem exists because the field of prevention is still in a formative stage. First, few studies have defined the nature and range of prevention services by identifying the strategies and techniques used in service delivery. Second, opportunities for training and skill development in prevention have been limited, making it difficult for prevention practitioners to develop requisite skills. Third, the concept of prevention has different meanings for different people.

147. **Lamb, H.R., & Zusman, J. (1979). Primary prevention in perspective. *American Journal of Psychiatry, 136*, 12–17.**

Discussion of primary prevention has been made difficult by lack of clarity of underlying concepts and assumptions, such as whether the purpose is to prevent diagnosable mental illness or to prevent unhappiness and social incompetence and whether there is a clear distinction made between major and minor mental illness. Except for a few specific conditions, little evidence exists that primary prevention has been effective. It is argued that research and program evaluation in prevention is needed but should be funded separately and with discretion. Scarce mental health funds should not be diverted from direct treatment for this purpose. ©APA.

148. **Lamb, H.R., & Zusman, J. (1981). A new look at primary prevention. *Hospital & Community Psychiatry, 32*, 843–848.**

Renewed interest in primary prevention accompanied by changes in conceptualization is discussed. New emphasis is placed on precipitating factors in mental illness, rather than causative factors, and on mental health promotion. Such reconceptualization probably stems from the lack of knowledge about specific causation of mental illness and the mounting evidence for genetic factors. Efforts to focus on precipitating stresses in persons already mentally ill, whether overtly or in remission, are commendable even though such efforts constitute secondary prevention. There is little evidence that mental health promotion is effective, at least if judged according to a decrease in diagnosable mental disorder. Research on primary prevention should be strongly urged, but, until the outcome of such research is learned, applied programs of prevention should proceed only on a pilot basis. (Author abstract modified)

149. **Lamb, H.R., & Zusman, J. (1982). The seductiveness of primary prevention. In F. D. Perlmutter (Ed.), *Mental health promotion and primary prevention* (pp. 19–30). San Francisco: Jossey-Bass.**

The complexities inherent in primary prevention are discussed with emphasis on serving the diagnosable mentally ill. Primary prevention includes activities that promote health generally and thereby increase resistance to disease, and activities that are aimed against the occurrence of specific illnesses. In the area of mental health, most successful primary preventive activities have been aimed at specific diseases. There is no evidence that general mental health can be promoted or strengthened. Therefore, there is no evidence that resistance to mental illness can be increased by preventive activities. Primary prevention is based on theories that cannot be shown to account for most cases of mental illness and in particular for the major mental illnesses. It is claimed that even if the underlying theory of environment as a cause of illness is accepted, there are still serious logical inconsistencies in the usual understanding of how primary prevention could work. It is suggested that research pertaining to prevention of mental illness be conducted prior to implementation of applied programs.

150. **Lamb, H.R., & Zusman, J. (1982). Reply to a comment. *Hospital and Community Psychiatry, 33*, 390–391.**

The authors write in response to a comment (abstract #137) written about their article (abstract #148) that appeared in the December, 1981 issue of *Hospital and Community Psychiatry*. As citizens, they support research and programs designed to combat the "adverse effects of, for example, discrimination, poverty, unemployment, and threats of war on healthy individual development." However, as psychiatrists, they do not consider these activities as primary prevention of mental illness "for there is no good evidence that they prevent the occurrence of diagnosable mental illness." They argue that averting human suffering is a worthy goal in and of itself without attempting to justify such efforts under the rubric of "primary prevention." The authors also suggest that mental health promotion efforts should not be seen as prevention of mental illness but as a means of attempting to improve human functioning. They state that such efforts should be shifted out of the mental health system and into such institutions as schools and well-baby clinics that are involved in the more normal processes of living.

151. **Landsberg, G. (1977). The state of prevention in mental health.** ***Perspectives in Psychiatric Care, 15*****, 15–17.**

The author discusses possible reasons for the ineffectiveness of preventive measures in mental health. One reason may be that definitions of prevention generally follow the public health model, or medical model, which is disease-oriented. Whether this model is really appropriate to mental illness and mental health is questioned. The use of oversimplified formulas, which implies extensive knowledge of the causes of mental illness, may lead mental health professionals to formulate unrealistic goals. The author describes from personal observation four unanticipated negative consequences of ventures in mental health prevention: (1) existing informal community and social mechanisms were seriously undermined, (2) community education changed community tolerance for deviant behavior, (3) prevention programs caused undue competition among community groups, and (4) consultation and educational services led community agencies to neglect direct program services and to shift responsibilities. Mental health professionals are cautioned to be aware of such problems, existing and potential. ©APA.

152. **Levine, M., & Perkins, D.V. (1980). Social setting interventions and primary prevention: Comments on the report of the Task Panel on Prevention to the President's Commission on Mental Health.** ***American Journal of Community Psychology, 8*****, 147–157.**

The conclusions and recommendations of the Task Panel on Prevention of the President's Commission on Mental Health are critically reviewed. The Task Panel made a strong recommendation in support of primary prevention activities. This new paradigm is based on the Task Panel's assumptions regarding the generalizations of the effects of various interventions in time and across situations. Alternative directions are proposed based on: (1) a more thorough understanding of environmental settings in terms of processes such as behavior-environment congruence and the development of setting taxonomies; and (2) attention to the importance of the person/environment fit and the implications of this process for person-centered competence building approaches. These new directions are offered as heuristic alternatives to the Task Panel proposals.

153. **Mariner, A.S. (1980). Benevolent gambling: A critique of primary prevention programs in mental health.** ***Psychiatry: Journal for the Study of Interpersonal Processes, 43*****, 95–105.**

The concept of prevention as applied to mental and emotional disorders is examined, and a critical assessment of allegedly preventive professional activities in mental health is presented. The concept of primary prevention as applied to disorders of organic, functional, and unknown etiology is considered. While prevention in organic conditions involves physical measures where etiology is known, organic syndromes are esoteric rarities in mental health practice. In conditions of unknown origin, little can be done in the way of prevention. While genetic research provides a theoretical basis for prevention (e.g., counseling schizophrenics not to have children), the practical value is questionable. The functional conditions (neuroses, reactive disorders, character disorders) have been the primary focus of preventive psychiatry. However, methodological problems make research into the etiology of such conditions difficult and the evaluation of preventive programs virtually impossible.

154. **Rappaport, J. 1981). In praise of paradox: A social policy of empowerment over prevention.** ***American Journal of Community Psychology,* 9, 1–25.**

This paper asserts that the most important aspects of community life are paradoxical, and that the task of researchers, scholars, and professionals should be to influence contemporary resolutions to paradox. First, the terms "paradox antimony, convergent and divergent reasoning, and dialectic" are described as fundamental to understanding the paradoxical nature of social/community problems. Next is a discussion of community psychology as a social movement, and the pursuit of paradox is advocated as an energizing image for the field. A brief social history follows with special emphasis on the dialectic between a "needs" perspective and a "rights" perspective. The imagery of prevention is seen as involving a "needs" conception of people, while the imagery of empowerment evokes a "rights" conception of people. Because the imagery of prevention is currently dominant, the author stresses the importance of advocating empowerment as an energizing rallying cry for the field.

155. **Runquist, M.P., & Behar, L.B. (1974). Prevention of mental health problems: Meeting needs or imposing values?** ***American Journal of Orthopsychiatry,* 44, 269–270.**

In this article, the ethical and practical problems in the application of the primary prevention concept are examined. Values of positive mental health are often discrepant from those of the caregivers who may or may not reflect shared values of the particular community. Only by professionals sorting out their own values and making them explicit can they help community members understand the value systems under which they are operating. From this approach it is easier for the consumer and the professional to reach consensus on what is to be prevented and what is to be encouraged.

156. **Szasz, T. (1981). On "preventing psychopathology": A libertarian analysis. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 26–33). Hanover, NH: University Press of New England.**

In this brief paper the author contends that there is no such thing as "mental illness" and thus prevention of psychopathology is meaningless. The author goes on to discuss some issues related to the labeling and treatment of persons diagnosed as having mental disorders. Also discussed is the issue of conflicting moral codes and lifestyles. The author discusses drug usage as an example of the conflict between individual freedom and social restraint.

157. **Wagenfeld, M.D. (1972). The primary prevention of mental illness: A sociological perspective.** *Journal of Health and Social Behavior, 13*, **195–203.**

An examination of empirical evidence largely fails to support the notion that mental illness is etiologically or sequentially associated with social conditions such as poverty and racism. Belief in the efficacy of primary prevention rests on ideological grounds. Some of the logical implications of these ideologies are examined and their significance for the future of mental health programs is assessed.

See also: 6, 22, 43, 44, 46, 56, 61, 78, 95, 162, 175, 297, 328, 717.

C. Barriers and Obstacles

This section consists of articles that discuss the barriers and obstacles, largely practical in nature, that impede the development of primary preventive research and interventions.

158. Albee, G.W. (1979). Primary prevention. *Canada's Mental Health, 27*, 5–9.

Obstacles to and strategies for primary interventions are discussed in relation to public health aspects of primary prevention of mental illness. Factors noted as related to the lack of widespread emphasis on prevention include the crises-oriented nature of U.S. politics and public policies; the commitment of mental health professionals to the values of the one-to-one intervention philosophy; the social and environmental changes required by prevention interventions; and the shortage of well-qualified people prepared to work and plan in the area. The utility of public health concepts and strategies in the area of prevention of mental illness is affirmed. It is contended that a public health approach can be employed without accepting the medical model of mental illness. Three approaches to reducing the incidence of mental disturbances in groups of people are described: (1) prevention or reduction of the influence of organic factors; (2) reduction of stress, and (3) increasing the competence of people to deal with life's problems, particularly with the problems of social interactions.

159. **Bloom, M. (1981). Analysis of the knowledge base of primary prevention. *Journal of Primary Prevention, 2*, 6–13.**

The knowledge base upon which primary prevention of psychopathology efforts might be founded is examined in light of the observation that primary prevention has already emerged as a top priority on the nation's agenda in the social psychological/medical arena. The results indicate that conventional published data bases are extremely deficient in preventive materials, and that computer based information systems are no better. It is concluded that researchers and practitioners cannot depend on automated or conventional sources for specialized topics, and suggestions are given for improving upon inclusion of primary prevention material in these systems. (Author abstract modified)

160. **Bolman, W.M. (1979). Obstacles to prevention. In I.N. Berlin, & L. A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 8–13). New York: Basic Books.**

This article describes four general categories of obstacles to the attainment of prevention programs. The first category is entitled "Problems of Values: The Ambivalent Status of Prevention" and discusses how value differences and the fact that activities designed to prevent trouble must usually be undertaken when people are trouble-free contribute to the ambivalent status of prevention. "Problems of Knowledge and Theory" states that the current meager level of knowledge and theory constitutes a significant obstacle. Difficulties in planning and coordinating are cited next, and the author emphasizes how the lack of consensus around common goals further hinders the development of prevention activities. Finally, problems of ignorance of various socioeconomic and political realities that affect professional support for preventive programs are mentioned. In spite of all these obstacles, the author remains optimistic in light of current research, service and legislative initiatives in the area of prevention.

161. Broskowski, A., & Baker, F. (1974). Professional, organizational, and social barriers to primary prevention. *American Journal of Orthopsychiatry, 44*, 707–719.

While the virtues of primary prevention seem to be gaining verbal support, the implementation of programs appears to be lagging behind. This article presents an overview of the barriers to primary prevention. They are discussed under four interrelated and at times overlapping categories: definitional problems, systemic complexity, difficulties of demonstration, and lack of demand by an established constituency. Under definitional barriers, the authors discuss the shortcomings of the medical-disease model for adequately conceptualizing or describing the complex issues in question. This relates to the second area, systemic complexity. The authors point to the need for more elaborate conceptualizations to include the variety of factors that influence mental health. This complexity contributes to the effectiveness of programs. The need for more and different training for professionals, to integrate research and service, as well as the need for development of more appropriate research designs and statistical procedures are highlighted here. The final barrier, lack of demand by an established constituency, is identified by the authors as potentially the most critical and most difficult to overcome. Part of the problem seems to be inherent in the nature of primary prevention, dealing with issues of susceptibility and promoting effective functioning. Individuals are less likely to see these issues as relevant to them and, with limited resources available, more visible, pressing needs are more likely to be supported.

162. Cowen, E.L. (1982). Primary prevention research: Barriers, needs and opportunities. *Journal of Primary Prevention, 2*, 131–137.

Barriers, needs, and opportunities in primary prevention research are discussed, with a focus on the imbalance between the field's language, concepts, and rhetoric and its research base. Three structural requirements of primary prevention are presented: (1) it must be group or mass, rather than individually oriented; (2) it must have a before-the-fact quality; and (3) it must be intentional, i.e., rest on a solid knowledge base suggesting the potential for improving psychological health or preventing maladaptation. At present, much of the field's knowledge base comes from generative research scattered throughout such diverse fields as sociology, psychology, family relations, education, and political science. Research demonstrating correlational or epidemiological relationships between situations, characteristics, or qualities and psychological outcomes provides a pipeline for future primary prevention programming and research. Because of the realities of prevention programs' environmental context, the diversity of its theoretical

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and knowledge base, and the variety of strategies and technologies used, primary prevention programming and research require significant recombinations of backgrounds, skills, and knowledge bases. The field could profit from heuristic program demonstrations based on a structurally demanding definition of primary prevention and supporting research documentation.

163. Cowen, E.L. (1982). The special number: A compleat roadmap. *American Journal of Community Psychology,10*, 239-250.

This article introduces a special issue on research in primary prevention by citing the criteria used for inclusion of articles; the similarities and differences betwen articles in terms of target population, methodology, goals, and evaluation; and their contribution to the field of primary prevention. As defined for the purposes of this issue, a primary prevention program had to be oriented to groups of people before the fact of maladjustment, have as its intent the enhancement of adjustment or the prevention of maladjustment, and include effectiveness data. The author describes deterrents to research in primary prevention including lack of definitional clarity in designing programs, the need for people with diverse skills and strong backgrounds across disciplines (beyond that provided by traditional mental health training), and firm commitment and persistence. He stresses also the need for both quality program planning and solid research to demonstrate programming effectiveness. The issue provides models of a variety of concrete approaches to primary prevention in mental health.

164. DeWild, D.W. (1980). Toward a clarification of primary prevention. *Community Mental Health Journal, 16*, 306-316.

Major problems blocking the implementation of primary prevention programs are discussed, along with ways to solve them. The ambiguity of the concept of primary prevention and a vague fear that primary prevention may violate civil liberties are two of the important barriers. Both these problems can be solved by dividing the concept of primary prevention into four distinct models: population welfare, population and adjustment, social action, and social ecology. These models were developed by intersecting intervention targets with sociopolitical values. The four models aid definitional accuracy and help identify and avoid those types of prevention interventions that do violate civil liberties. (Author abstract modified)

165. **Iscoe, I. (1981). Conceptual barriers to training for the primary prevention of psychopathology. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 110–134). Hanover, NH: University Press of New England.**

This article begins by discussing some of the barriers to setting up prevention programs. A major barrier is that potential beneficiaries are not visible whereas those already suffering from a mental disorder are visible. The author emphasizes the important effect that monetary support has on whether prevention or treatment approaches are implemented. Barriers to training for the primary prevention of psychopathology are seen as a manifestation of social policy, which places treatment ahead of prevention. It is pointed out that the field of clinical psychology began with a treatment focus, and until recently there has been a demand for the diagnostic and treatment skills of psychologists in clinical settings. Prevention is rarely discussed in graduate school, and jobs for which graduates would qualify do not emphasize prevention. At present, the majority of psychologists involved in the training of primary prevention have received most of their prevention orientation from schools of public health at the postdoctoral level. To promote efforts at primary prevention and the training of psychologists informed about prevention, the author suggests the following: (1) an APA task force to develop a position paper on primary prevention; (2) a prevention component to all APA approved clinical psychology training programs; (3) NIMH training support for primary prevention training; (4) Federal funding of primary prevention efforts; (5) national mental health organizations and the public should advocate funding of preventive intervention; and (6) the public, mental health professionals, and policymakers should begin to focus more on prevention as opposed to treatment of mental disorders.

166. **Okin, R.L. (1977). Primary prevention of psychopathology from the perspective of a state mental health program director. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol 1: The issues* (pp. 289–296). Hanover, NH: University Press of New England.**

Discussed are reasons for focusing on prevention, which include (1) insufficient resources to treat all mental illness; and (2) the profound effect of psychopathology on the individual, others, and society at large. A list of obstacles in achieving primary prevention is enumerated, including: lack of knowledge of normal and pathological development; methological problems; interacting factors associated with psychopathology; and delayed effects from certain causes. Past problems of the mental health system and society at large in promoting prevention are described. Suggestions for overcoming these obstacles include: (1) changing the emphasis in professional schools from treatment to child development, methods of consultation, and practical experience; (2) increasing efforts to alter the institutions that affect children (e.g., school systems); and (3) having human service constituencies begin to view their separate interests as interdependent.

167. **Perlmutter, F.D., & Vayda, A.M. (1978). Barriers to prevention programs in community mental health centers. *Administration in Mental Health*, 5,** 140–153.

The authors survey the attitudes toward prevention programs of 300 administrative and professional staff members of community mental health centers, with emphasis on their perceptions of primary prevention activities. Various obstacles to preventive work are specified. ©APA.

168. VanAntwerp, M. (1971). The route to primary prevention. *Community Mental Health Journal*, *7*, 183–188.

It is now known, from the opinions of key mental health professionals, why primary prevention plays so small a part in community mental health programming. It is not simply that we do not know how to accomplish it or because the etiology of mental illness is so vague. Instead the problems are practical: seeking change through social planning and social action is uncomfortable for mental health professionals; the clinical orientation of professionals has kept the public from understanding what primary prevention is all about; and funding mandates give priority to tertiary prevention. The broad involvement of community mental health centers in their communities has the potential for developing powerful support for primary prevention. (Author abstract) ©Human Sciences Press.

See also: 8, 15, 18, 25, 44, 61, 65, 66, 79, 104, 106, 114, 119, 174, 180, 186, 188, 476, 560, 680, 820, 835, 944, 958, 963.

D. Funding and Economic Issues

Articles that discuss problems or issues with funding primary prevention efforts are included in this section. Also listed are articles that debate the cost benefits and economic implications of primary preventive interventions.

169. **Balch, P., & Harper, R. (1976). Prevention, psychologists, and economics: A reply to Wolf. *Professional Psychology, 7,* 650–653.**

The authors respond to the claims made by M.G. Wolf, (abstract #178) in criticism of the present author's article (abstract #174). The present author asserts that Wolf seriously misread and/or misunderstood both the economic and social implications of their arguments for primary prevention. They continue to maintain their arguments and further attempt to explicate them as valid. ©APA.

170. **Balch, P., & Harper, R. (1976). A further note on economics and primary prevention: Reply to a comment. *Professional Psychology, 7,* 655.**

In response to a series of articles on economics and primary prevention (Harper, Balch, 1975, 1976, and Wolf, 1976), it is contended that Wolf's criticism is due to a misunderstanding of accepted economic practice, that both graphs representing supply/demand curves are hypothetical, and that when marginal revenue is below average cost and average cost is below price there will still be profit. It is further noted that monetary considerations are not the prime factor in a decision to enter psychology. It is concluded that a criticism of economic fallacies is invalid, and it is hoped that the emphasis on economics has not detracted from the original goal of stimulating discussion on primary versus tertiary prevention and optimal resource allocation.

171. **Baxter, F.Z. (1977). Funding—who pays when nobody's sick? In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 100–102). (DHEW No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

Funding resources for primary prevention mental health programs, reviewed at the April 1976 NIMH/NAMH Pilot Conference on Primary Prevention, are outlined. Federal programs that provide funding include those mental health programs in the areas of community mental health programming, consultation, and education; rape prevention and control; applied research; children and family; aging; crime and delinquency, crime and minorities; drug and alcohol prevention, treatment, and education; developmental disabilities; health revenue-sharing grants; low-income housing for the elderly or handicapped; and funds available under the Child Abuse Prevention and Treatment Act, the Elementary and Secondary Education Act, and the Social Security Act. New legislation, funding information resources, government contracts, State and local monies, and private sources are also mentioned.

172. **Dorr, D. (1972). An ounce of prevention (means more for your money). *Mental Hygiene, 56*, 25–27.**

Application of cost benefit data to a school based preventively oriented mental health project demonstrates the use of fiscal arguments in gaining support of expanded high quality services to children. Much of the rationale of preventive programs relies on the assumption that the long-term savings for society will more than repay short-term investments in diagnosis and treatment. The use of paraprofessionals as a relatively low cost supplement to professional treatment teams is discussed.

173. **Gullotta, T.P. (1981). An unorthodox proposal for funding primary prevention. *Journal of Primary Prevention, 2*, 14–24.**

A model for financing prevention programs for mental illness through the private sector is proposed in light of observations that treatment advocates are unwilling to share finding with prevention advocates. The necessary methods for implementing the model are described and three examples are provided of prevention initiatives where the model can be applied. The model is considered unique in that: (1) it ventures directly into the private sector, but does not involve the insurance industry; (2) it can be implemented by the private practitioner as well as the CMHC or family agency; and (3) it may enable an alliance of the private sector and the prevention community that may generate new models. (Author abstract modified)

174. **Harper, R., & Balch, P. (1975). Some economic arguments in favor of primary prevention. *Professional Psychology, 6*, 17–25.**

Mental health is an industry in which primary, secondary, and tertiary prevention activities can be viewed as businesses subject to economic analysis in terms of supply and demand, cost, and efficiency. It is argued that tertiary-secondary prevention commands almost all of the demand for and supply of mental health services, a monopolistic situation which is economically inefficient in terms of cost to society and expense to the people requiring the services. Resources are underallocated in the primary prevention sector such that the marginal cost of services may well be greater than it would be with increased utilization. These economic considerations argue for a reallocation of existing resources away from tertiary-secondary prevention sectors to the primary prevention sector.

175. **Pickett, G. (1983). Prevention in a free society. *Journal of Primary Prevention, 3*, 215–223.**

While knowledge required for prevention can be derived from epidemiological studies, additional effort is needed from economists, behavioral scientists, and others to explore the costs of different health problems, the cost and benefits of intervention, and the social acceptability of the activity. The tendency of health professionals is to apply medical techniques to prevention without exploring the efficiacy, efficiency, or acceptability of nonmedical alternatives. The overall results of nationally sponsored prevention efforts have been disappointing. An attempt to align public prevention expenditures with objectively derived priorities provokes a question as to whether planning and priority setting for prevention can be done efficiently in the United States. (Author abstract) ©Human Sciences Press.

176. Ruiz, P. (1979). The fiscal crisis in New York City: Effects on the mental care of minority populations. *American Journal of Psychiatry, 136*, 93–96.

The author describes the effect that severe budget cuts accompanied by guidelines stipulating that direct services be given priority over primary preventive services had on a community mental health center in New York City. He focuses his discussion on the effect these guildeines had on mental health care services provided the minority populations served by the center. Before the budget cuts, one out of every four staff members was a nonprofessional indigenous worker. After the cutback, two out of every three of the people laid off were nonprofessionals. The author provides a number of recommendations to help government agencies plan budget reductions without sacrificing primary prevention efforts. (Author abstract)

177. **Scheffler, R.M., & Paringer, L. (1980). A review of the economic evidence on prevention. *Medical Care, 18*, 473–484.**

Economic evidence on preventive health care is examined, including benefit cost analysis and cost effectiveness analysis, their applications to preventive strategies, and the problems of implementing these approaches. Prevention strategies are grouped into three categories: lifestyle changes, public health measures, and screening programs. Lifestyle changes include altering behavior patterns as they relate to alcohol and drug abuse, smoking, and automobile safety regulations. Included in public health measures are immunizations against communicable diseases, water fluoridation, and food inspection. Screening includes programs for detection of phenylketonuria and congenital hypothyroidism in newborn infants, spina binifida cystica in the unborn fetus, and hypertension. It is concluded that many of the preventive health measures represent an efficient use of resources and that the actual value of preventive strategies may be understated since reductions in pain and suffering are usually omitted. (Author abstract modified)

178. **Wolf, M.G. (1976). Some economic arguments in favor of higher fees for tertiary-secondary mental health services. *Professional Psychology, 7*, 646-650.**

This article is in response to an article written by Harper and Balch (1975) (abstract #174). The author criticizes some of the conclusions reached. The criticisms are focused on the perceived misuse of economic principles that Harper and Balch used to justify primary prevention activities over secondary and tertiary services. The criticisms made are not in reference to Harper and Balch's thesis about the value of allocating greater amounts of money for primary prevention, but with regard to the economic principles used to support the thesis.

179. **Wolf, M.G. (1976). Economic issues about economics: A comment on a reply to Wolf. *Professional Psychology, 7*, 653-654.**

In response to a series of articles on economics and primary prevention (Harper, Balch, 1975, 1976 and Wolf, 1976), it is contended that: (1) there is no inconsistency between an increasing supply of professional manpower and the presence of constraints on further expansion of supply; (2) a ratio of 2.5 applicants for each position in the mental health field does not necessarily indicate an oversupply of trained professionals, as an applicant may already be employed and may apply for more than one position; (3) the distinction between professionals willing to work and actually working is an important one; and finally (4) criticism of the thesis that more funds be allocated to the preventive sector of mental health care was not intended; rather criticism was aimed at the fallacious use of economics and logic by Harper and Balch in defending that thesis.

See also: 53, 66, 127, 137, 186, 188, 195, 238, 240, 882, 889, 928, 983.

E. Political and Federal Issues

Articles in this section discuss the role or the present political position of the Federal government regarding primary prevention. Several articles address the ramifications of various political and Federal issues on primary prevention.

180. **Brown, B.S. (1978). Conflict and detente between social issues and clinical practice. In *Trends in mental health*. (DHEW Pub. No. (ADM) 78-610). Washington, DC: U.S. Government Printing Office.**

The dual nature of the mental health profession, which is embodied in the differences between advocates of social and clinical approaches to people's problems, is discussed. The scope of the problem is illustrated by the Senate subcommittee hearings on the renewal of the Child Abuse Treatment and Prevention Act. The impact of the community mental health center (CMHC) program's identity as a clinical services model, which parallels and even predates its emergence as a social change force, is discussed, and it is shown that the process of conflict and change is best seen through the third dimension of CMHC identity, that of a new administrative and organization model for mental health services. The dynamics of this process are illustrated by a discussion of the relationship of the medical model, the multidisciplinary nature of the CMHC, and consumer participation. It is shown that prevention sets the stage for conflict in the health professions.

181. **Goldston, S.E. (1977). Primary prevention: A view from the Federal level. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 1: The issues* (pp. 297-315). Hanover, NH: University Press of New England.**

Attitudes and programs needed for primary prevention are cited, including a reorientation of priorities so that planned active programming will replace reactive responsiveness to the field, and so that a commitment at the policy and operating levels will provide support, encouragement, resources, and sanction for prevention activities. Present program considerations and themes are: (1) Sudden Infant Death Syndrome (SIDS); (2) mental health and family planning, (3) new mothers and neonates, and (4) children in the hospital.

182. **Goldston, S.E. (1979). Primary prevention programming from the Federal perspective: A progress report. *Journal of Clinical Child Psychology, 8*, 80-83.**

Recent developments in Federal primary prevention program planning are discussed. Mental health prevention initiatives originally were based on a four point conceptual framework: (1) mental health promotion; (2) disease/disorder prevention; (3) prevention of behavioral consequences; and (4) prevention of behavioral antecedents. More recently the elements of the fiscal year 1980 prevention plan for research are being examined. Efforts will be directed at developing a program focused specifically on a particular aspect of the total mental health problem. Initially work will concentrate on developing interventions for children in families undergoing marital disruption. The most recent draft of the proposed Mental Health Systems Act contains a separate title on prevention with provisions to assist State efforts concerned with the promotion of mental health and the prevention of mental illness. It is suggested that unique opportunities exist to demonstrate the effectiveness and relevance of primary prevention.

183. **Goldston, S.E. (1980). Primary prevention: Perspectives from the national level. In H. Staulcup (Ed.), *Primary prevention in social work* (pp. 31–43). St. Louis, MO: Washington University Press.**

Forces that are influencing trends in primary prevention in community mental health programs and problem areas for which primary prevention approaches are applicable within the context of current Federal prevention planning efforts are described. The approach to prevention supported by the U.S. Public Health Service is threefold: reduce deleterious lifestyle behaviors (e.g., smoking, overeating, insufficient exercise, and alcohol misuse); modify the physical and psychosocial environment; and provide preventive services. The approach to prevention supported by ADAMHA is fourfold: promote mental health, prevent disease, protect against the consequences of disease, and prevent antecedent high-risk behavior. Subject areas of new prevention intitiatives include fostering the mental health of children experiencing the stressful life-event of hospitalization, promoting parental competency and preventing postpartum disturbances, and promoting effective coping among family members experiencing marital separation/divorce.

184. **Kennedy, J.F. (1967). The role of the Federal government in the prevention and treatment of mental disorders. In S.K. Weinberg (Ed.), *The sociology of mental disorders* (pp. 297–300). Chicago: Aldine.**

This is part of the text of a speech, "Mental Illness and Mental Retardation," given by President Kennedy to the House of Representatives on February 5, 1963. The President states in his speech that "a concerted national attack on mental disorders is now both possible and practical" given new developments in the mental health field. Kennedy recommends the formation of comprehensive community mental health centers. He states that "prevention as well as treatment will be a major activity" of these centers. The President then describes how the development of these CMHCs should proceed, how they should function, and what services they should provide. The President specifies that the needs of the mentally retarded should be considered in the services offered by these centers. In addition, Kennedy discusses the need for improved care in State mental hospitals, the need for more research, and increased professional manpower in the mental health field. The appropriation of funds for these endeavors is outlined. Finally, the President states: (1) the need for improved quality of care for the mentally ill and mentally retarded, (2) the need to attempt to "prevent the occurrence of mental illness and mental retardation wherever and whenever possible," (3) the need to provide for early diagnosis and continuous and comprehensive care, and (4) the need to reduce the number of institutionalized persons and help them lead productive lives in the community. In conclusion, Kennedy states, "We must promote--to the best of our ability and by all possible and appro- priate means--the mental and physical health of all our citizens."

185. **Perlmutter, F. (1974). Prevention and treatment: A strategy for survival. *Community Mental Health Journal, 10,* 276-281.**

It is proposed that prevention activity in community mental health centers will no longer be a problem since it will be altogether eliminated in the present National Institute of Mental Health (NIMH) design and that, if prevention is indeed a valid activity in community mental health, alternate strategies must be sought. Previous studies are cited, as well as current NIMH priorities, to support the argument that prevention activity must be organizationally separated from service delivery. A strategy of "structural segmentation" is offered to include the use of voluntary auspices to protect the program objective of primary prevention.

186. **Plaut, T.F. (1980). Prevention policy: The Federal perspective. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research policy and practice* (pp. 195-205). Beverly Hills: Sage.**

The chapter entitled "A Strategy for Prevention," which appeared in the 1978 report from the President's Commission on Mental Health, is described along with general policy issues in the field of prevention as considered from the Federal perspective. The Commission recommended that NIMH establish a Center for Prevention with primary prevention its major priority and that $10 million be provided for NIMH prevention activities with a 10-year goal of 10 percent of the total NIMH budget to be devoted to preventive activities. General policy issues in mental health prevention include concern about the adequacy of the current knowledge base as a foundation for preventive efforts, identification of appropriate targets for these efforts, the establishment of boundaries of prevention activities, evaluating program effectiveness, and coordinating and collaborating with other mental health service providers.

187. **Plaut, T.F. (1982). Some issues from the Federal vantage point. *Journal of Children in Contemporary Society, 14,* 101–107.**

Mental health promotion and mental illness prevention activities at the Federal level are viewed in the context of recent developments in both mental and general health. Different target groups for such programs are listed, as are different "levels" of prevention. The adequacy of the current knowledge base for prevention work is reviewed. Basic principles underlying the current prevention/promotion activities of the National Institute of Mental Health are also presented. ©APA.

188. **President's Commission on Mental Health (1978). Report of the task panel on prevention. In D.G. Forgays (Ed.), *Primary prevention of psychopathology, Vol. 2: Environmental influences* (pp. 207–249). Hanover, NH: University Press of New England.**

Prevention of emotional disorders is seen as the fourth mental health revolution. Primary prevention means lowering the incidence of emotional disorder by (1) reducing stress and (2) by promoting conditions that increase competence and coping skills. Barriers to primary prevention efforts are identified. Several representative research areas are reviewed in order to show that a solid research base exists for primary prevention. An important "paradigm shift" identified is that just as an emotional disorder may result from any of several background factors and life crises, so can any specific intense stressful life event precipitate any of a variety of emotional and mental disorders. Recommendations include a coordinated national effort toward the prevention of emotional disorder with a Center for Primary Prevention within the National Institute of Mental Health; a priority on infants and young children (and their social environments); a national effort to reduce societal stresses produced by racism, poverty, sexism, ageism, and urban blight; and increased funds to support training, program development, and research in the area of prevention.

See also: 3, 31, 79, 127, 166, 191, 221, 361, 963.

F. Primary Prevention and Public Policy

This section contains articles on social and public policy considerations that are related to various efforts at primary prevention. Other articles discuss the setting of national public policies regarding prevention.

189. **Clark, K.B. (1981). Community action programs—an appraisal. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol 5: Prevention through political action and social change* (pp. 153–162). Hanover, NH: University Press of New England.**

The author describes his experiences with the Harlem Youth Opportunities Unlimited community action project. The author states that the tremendous social problems that are prevalent in ghettos such as Harlem can never be eradicated without a reduction in social injustices and inequities affecting residents in these urban areas. The author concludes that if community action programs are to ever play a role in the primary prevention of psychopathology, the following will have to occur: (1) genuine commitment to social, racial, and economic change on the part of the decisionmakers of society; (2) social and economic support of these programs; (3) training of indigenous nonprofessionals who will participate in the process of social change, and (4) training of professionals who will have empathy and respect for the potential and the humanity of victims of social inequities.

190. **deLone, R.H. (1982). Early childhood development as a policy goal: An overview of choices. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 485–502). Hanover, NH: University Press of New England.**

Public policymaking is viewed as an approach to facilitating development in children. The author stresses the need for policy to be funded by sound theory, which can be translated into an adequate policy framework with a delivery system capable of carrying out the policy and a practicable set of techniques of delivery. Due to scarce resources of public funds for programs for children, it is of great importance to link policy to child development theory and to clear goals that are capable of being evaluated. The author discusses these criteria for good policy and how one might test for their presence in public policy for children.

191. **Department of Health, Education and Welfare. (1977). *Summary proceedings tripartite conference on prevention*. (DHHS Pub. No. (ADM) 77–484). Washington, DC: U.S. Government Printing Office.**

This 100-page booklet describes the proceedings of a 1976 conference of representatives from Canada, the United Kingdom, and the United States held at the Smithsonian Institution in Elkridge, Maryland, on the subjects of prevention policy, planning, and programming in the areas of alcoholism, drug abuse, and mental health. A conference goal was to "possibly take the first steps toward future cooperative or collaborative prevention activities among the participating countries." The first section of the booklet discusses the extent of the problems of alcoholism, drug abuse, and mental health disorders in the three countries. In the next section, conference members' discussions concerning the setting of national policies on prevention, various prevention strategies, treatment as prevention, and research relevant to prevention concerns are highlighted. Finally, political issues involved in prevention and health promotion are discussed, and proposals developed at the conference concerning collaborative preventive intervention and research efforts between the three nations are listed.

192. **Hilbert, M.S. (1977). Prevention. *American Journal of Public Health, 67*, 353–356.**

The status of prevention as a public health priority is discussed in this presidential address for the 104th Annual Meeting of the American Public Health Association. In the broad context, prevention is defined as encompassing societal nonspecific factors such as health education, adequate housing, good nutrition, and an environment that is both physically and emotionally safe. The increase in the amount of the Gross National Product expended for "sickness care" is shown to reflect an ever-increasing investment of public and private resources in "illness" rather than "wellness." It is argued that this crisis-oriented system of rewards for the treatment of sickness must be changed to a system offering incentives for health promotion.

193. **Ramey, C.T. (1974). Children and public policy: A role for psychologists. *American Psychologist, 29*, 14–18.**

The author discusses the 1970 Joint Commission on Mental Health of Children report. The issues raised by the report are considered, and recommendations are presented for the response of the American Psychological Association (APA). The limitations of the APA in the area of its official position on public policy or programs, the establishment of priority statements after anlayses of program costs, and the utilization of lobbyists are discussed. It is suggested that psychologists establish rank order priorities for the problems of prevention of psychopathologies in children. The advantages of the child advocacy system and of universally available preschool programs, especially for the disadvantaged, are discussed. Research is proposed that would cover three areas: nationwide epidemiological studies, assessment and evaluation of action-oriented social programs, and multidisciplinary research into causative factors. A general model for delivering services to children and families is outlined that would utilize the local schools as the first level for assessment and treatment. ©APA.

194. **Sarason, S.B. (1983). Psychology and public policy: Missed opportunity. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 245–250). New York: Pergamon Press.**

The author asserts that any individual or field that purports to be interested in understanding and/or influencing the dynamics of our communities must become sophisticated about public policy, since policy reflects and exposes community organization, relationships, and dynamics. The unrelatedness of community psychology to the arena of public policy is discussed with special attention to its roots in clinical psychology. The birth of community psychology as a revolt against the traditional clinical model has limited its scope. While many community psychologists evaluate the consequences of public policies already in place, few influence the development of policy. The author suggests that community psychologists become activists in the process of researching and understanding social phenomena.

195. **U.S. Department of Health and Human Services (1981). *ADAMHA prevention policy and programs (1979–1982).* (DHHS Pub. No. (ADM) 81-1038). Washington, DC: U.S. Government Printing Office.**

This 65-page booklet outlines the present policy of the Alcohol, Drug Abuse, and Mental Health Administration toward primary prevention as well as likely future program directions. Current prevention activities, budget estimates, and future program directions of NIAAA, NIDA, and NIMH are discussed. Prevention concepts, strategies, and unresolved issues are also included.

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196. **Zigler, E., & Finn, M. (1982). A vision of child care in the 1980's. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol 6: Facilitating infant and early childhood development* (pp. 443–465). Hanover, NH: Univeristy Press of New England.**

Information gathered about children in the United States in 1979, the International Year of the Child, is presented. The facts include high infant mortality rates for nonwhite babies, the absence of minimal level of prenatal care for many women, a high number of teenage pregnancies, inadequate health care for many children, the high incidence of child abuse, and an increase in the incidence of depression among children. The authors then present their vision of child care in the 1980s. They encourage greater involvement of the private sector in matters pertaining to family life, given the current diminishment of government action. They propose the development of referral information centers in each community, the improvement of foster care, the extension of education to prenatal and early infant-parent education programs, publicly supported child care centers, greater quality control of day care centers, and increasing the role of the workplace in supporting family life.

See also: 19, 21, 31, 49, 57, 58, 76, 85, 123, 125, 134, 165, 173, 175, 184, 211, 223, 226, 240, 241, 265, 283, 352, 361, 406, 411, 442, 543, 553, 554, 555, 560, 605, 621, 647, 648, 750, 778, 830, 869, 876, 943.

III. Primary Prevention and Allied Mental Health Fields — Mental Health Professionals

Articles in this section address the professional practices and concerns of a specific field (or subdiscipline of a field) of mental health. Some articles address what type of involvement a mental health field and its member professionals should have in primary prevention. Other articles discuss the present involvement of a field or its professionals in primary prevention activities.

A. Psychology — Psychologists

197. **Albino, J.E. (1983). Health psychology and primary prevention: Natural allies. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice*** (pp. 221–233). New York: Pergamon Press.

The parameters of health psychology are outlined, including the role of psychologists in the health care system, health maintenance, helping clients with lifestyle changes, working with an individual on pain management, etc. The author links the work of health psychologists with primary prevention: reducing the rate of occurrence of medical disorders and increasing or prolonging the maintenance of health. Issues in primary prevention are discussed along with relevant research. Areas of overlap between the interests of psychologists in health and those in mental health settings include identifying risk factors in health maintenance and developing programs to reduce risk, adhering to health recommendations, coping with life stress, and developing effective health care delivery systems. Collaboration among psychologists in varied settings is urged.

198. **Balding, J., & Nichols, K. (1978). Preventative education in mental illness: A role reversal for educational psychologists? *Journal of the Assocation of Educational Psychologists, 4,* 33–36.**

The authors point out the importance of establishing educational programs to help people cope with such life experiences as depression and anxiety. In England, educational psychologists are best prepared to handle such programs in schools and should encourage their development. ©APA.

199. **Bell, A.A., Carroll, J.F., Brecher, H., & Minor, M. (1972). Psycho-educational services for elementary schools: A preventive systems approach. *Journal of the National Medical Association, 64,* 427–431.**

A new mode of functioning for school psychologists and counselors based upon an ecological, preventive model of psychosocial services is described. It entails an active reaching out or the initiating of various programs intended to enhance key systems that affect children's learning and emotional growth and development. This model differs sharply from traditional counseling and guidance programs. Four project-wide programs are described to illustrate how the project actually operates in the schools. Additional activities being employed in the schools include new curriculum materials, tutorial services, utilizing community resources in the classroom, developing athletic programs, a bilingual instructional program, gang control, and drug abuse prevention programs. Teams serve primarily as consultants, stimulators, and facilitators rather than as the expert who delivers such services. The primary goal is to enhance existing systems by positively influencing key persons within these systems to function more effectively, and to facilitate intersystem communications and cooperation so that children will have a better chance at realizing their fullest potentials for learning and emotional growth and development. (Author abstract modified)

200. Caplan, G. (1963). **Opportunities for school psychologists in the primary prevention of mental disorders in children.** ***Mental Hygiene, 47***, 525–539.

This article outlines the goal of primary prevention as the provision of adequate physical, psychosocial, and sociocultural supplies that help individuals avoid stress and increase their capacity for future coping. Crisis theory is highlighted as a useful intervention model because in times of crises persons are not only vulnerable to maladaptation but also have an opportunity to be strengthened by the crisis. Implications of these ideas for primary prevention in the schools are then discussed, using examples. Particular attention is given to the potential role of the school psychologist in identifying crises in young children. Various interventions, including anticipatory guidance and consultation and collaboration with teachers, are outlined. Finally, the importance of the potential research role of the school psychologist is stressed.

201. **Goodyear, R.K.** (1976). **Counselors as community psychologists.** ***Personnel and Guidance Journal, 54***, 513–516.

A framework for the interventions in community psychology is presented in the hope of resolving the identity problems of the counseling psychologist. It is stated that the essence of the community psychology movement is prevention involving different levels of intervention: (1) primary prevention, consisting of working to prevent dysfunction within the general population by actively changing environments and settings and by teaching life skills; (2) secondary prevention, consisting of working directly with clients to resolve relatively mild disorders and/or crises; and (3) tertiary prevention, consisting of working to minimize the residual effects of severe and chronic problems. Counselor activities at each of these levels of interventions are outlined. It is believed that by claiming a piece of the community psychology turf, counselors will have the well-defined sense of professional boundaries needed to defend against the encroachment of sister professions as well as clear rationale for the whole spectrum of counseling activities.

202. **Hansen, F.K. (1981). Primary prevention and counseling psychology: Rhetoric or reality? *Counseling Psychologist, 9,* 57–60.**

The failure of counseling psychology to take a leadership role in primary prevention is addressed, along with the movement of community psychology to fill this void. It is argued that counseling psychology is neither strongly committed to nor systematically involved in primary prevention; that it is deeply ambivalent toward preventive mental health; and that it has, by default, allowed community psychology to dominate this field. Since prevention is basic to the identity of counseling psychology, this failure is seen as a serious development. It is proposed that the discrepancy between public statements and reality must first be considered and a commitment to primary prevention must be operationalized in the form of significant changes in professional training programs for counseling psychologists.

203. **Kelly, J.G. (1971). The quest for valid preventive interventions. In G. Rosenblum (Ed.), *Issues in community psychology and preventive mental health* (pp. 109–139). New York: Behavioral Publications.**

Three contrasting approaches for preventive interventions are described to suggest new criteria for developing programs in community mental health. These are: (1) consultation methods; (2) organizational change methods; and (3) development of the community as an evolutionary process. The main thesis is that the community psychologist views the development of knowledge as an ecological enterprise in which the conditions for verification are defined in terms of the specific host environment and its requirements for intervention. Each of the three types involve unique experimental designs and methods of quality control that generate specific ethics and provide for the observation of naturally occurring events to help confirm or deny the effects of interventions. This kind of research requires a strong commitment to longitudinal studies as well as the development of facilities organized to take account of unanticipated community events.

204. **Lapides, J. (1977). The school psychologist and early education: An ecological view. *Journal of School Psychology, 15,* 184–189.**

An ecological view of psychological services to preschool children is described here as a proactive, seeking-out, mental health delivery system that concentrates its effort on prophylactic activities. This contrasts with the reactive "wait for the referral" approach. This preventive function is seen to be of primary importance because it reaches out to improve the mental health of all children, families, and staff and does not limit mental health services solely to the ones who have developed problems. Activities for psychological services, training of staff, and competencies for effective delivery are described, as well as staff competencies to facilitate children's mental health. It is acknowledged that to date little or no research exists to demonstrate that preventive mental health activities as outlined here make a difference to children. ©APA.

205. **Lopez, R.E., & Cheek, D. (1981). The prevention of institutional racism: Training counseling psychologists as agents for change. In E.M. Myers (Ed.), *Race and culture in mental health service delivery systems* (pp. 34–49). Washington, DC: University Press of America.**

The role that counseling psychologists can play in the prevention of institutional racism is addressed with emphasis on a project that was designed to increase communication among Chicanos and blacks in a university setting. Implications for training counseling psychologists as change agents also are considered. It is suggested that primary prevention programs should focus on the identification of the causes of problems encountered by minorities, and on developing environmental and psychological support. It is suggested that as change agents, counseling psychologists must involve themselves in affirmative action programs, workshops on institutional racism, and programs of cultural awareness. The university project was designed to reduce fighting between blacks and Chicanos. A group met weekly for 1 hour to discuss problems they were having with each other and/or with the majority white power structure. The counseling psychologist was called upon frequently to mediate the expression of previously unspoken feelings. A perceived prejudice scale and exercise for reducing prejudice also were developed. It is suggested that prevention and education, rather than crisis intervention, should be emphasized in the training of counseling psychologists.

206. **Patrick, G.L., Saudargas, R.A., & Wiberly, J.A. (1980). The role of the school psychologist in the practice of the developmental optometrist. *Psychology in the Schools, 17*, 87–89.**

This paper discusses a cooperative effort between developmental optometrists and school psychologists in meeting the social and educational needs of children with vision problems. The private practice of the optometrist would provide a setting for practicing community-based preventive psychology. The role of the applied psychologist in providing psychological and educational assessment, consultation services, directed psychological interventions in the form of counseling and family therapy, and coordination of services is discussed. ©APA.

207. **Rappaport, J. (1977).** ***Community psychology: Values, research, and action.*** **New York: Holt, Rinehart, and Winston.**

This book is a comprehensive text concerned with the directions community psychology should take in dealing with social problems in education, mental health, and criminal justice. A history of events that led to the development of community psychology is outlined, and the ways in which social forces, politics, and human values have shaped social science and the helping professions are discussed. The conceptions that provided a basis for community mental health systems and the status of community mental health today are described, and the view that systems-oriented prevention is needed is advanced. Other topics for discussion include: (1) social learning and behavior modification; (2) personality theory and research; (3) primary prevention; (4) systems for change at the organizational and institutional level; (5) social intervention strategy; (6) applications of child psychology; (7) educational policy reform aimed at dealing with the cultural realities of the disadvantaged; (8) mental hospital closures; (9) crisis intervention strategy; (10) criminal justice system intervention strategy; (11) law enforcement reform; (12) crime and violence prevention; (13) training and utilization of nonprofessionals including volunteer mental health workers; and (14) community psychology manpower training trends.

208. **Wright, L. (1982). Primary versus secondary and tertiary levels of mental health care.** ***Clinical Psychologist, 35,*** **3–4.**

The author argues that more psychologists should be trained to do work and research on the kinds of mental health care provided in nonmental health settings. Bibliotherapy, research on process and outcome, and self- or parent-administered compliance programs are suggested as areas in which clinical psychologists can promote primary mental health care. ©APA.

See also: 29, 51, 52, 60, 72, 91, 114, 118, 141, 193, 194, 406, 535, 716, 794, 827, 904, 909, 911, 936, 981.

B. Psychiatry - Psychiatrists

209. **Berman, S. (1974). The relationship of the private practitioner of child psychiatry to prevention.** ***Journal of Child Psychiatry, 13*** **593–603.**

An overview of an area of involvement by child psychiatrists, especially those in private practice, that has not been adequately recognized for its rich potential value in prevention is presented. The report of the Joint Commission on Mental Health of Children (Crisis in Child Mental Health, 1969) is criticized for its omission of recognition of the involvement of child psychiatrists in a broad and varied range of experiences--clinical, educational, consultative, administrative, and research--that are relevant to preventive measures. Prevention is considered as related to child psychiatric practice, mental health training, public health services, social institutions, and mental health legislation. The child psychiatrist in private practice contributes extensively to all these phases of child mental health services, and it is suggested that it is essential that his/her participation be coordinated with any programs related to prevention. (Author abstract modified)

210. **Caplan, G. (1976). Community psychiatry: The changing role of the psychiatrist. In S. K. Weinberg (Ed.), *The sociology of mental disorders* (pp. 301–309). Chicago: Aldine.**

The author discusses the opportunities and implications that President Kennedy's speech (see abstract #184) to the Congress on February 5, 1963 might have for psychiatrists. The author contrasts the changing role of the community psychiatrist, who is involved both in the treatment of individuals and efforts to prevent mental disorders, with that of the psychiatrist who functions in the confines of a private office. The author differentiates between direct vs. indirect methods of affecting individuals in organizations and communities, with the latter strategy being more preventive and broader-reaching in nature. Finally, the author states the need for community psychiatrists to maintain a preventive orientation in their endeavors.

211. **Caplan, R.B. (1969). *Psychiatry and the community in nineteenth-century America*. New York: Basic Books.**

This book presents a history of psychiatry, tracing its ideas and theories on treatment and prevention of mental illness from the 19th century up into the 20th century. The author attempts to show how ideas in psychiatric practice have appeared, disappeared, and reappeared again throughout the decades. The author states that when one traces themes through American psychiatry over the last century, one realizes that many of the theories considered most revolutionary today have emerged and disappeared over and over in the past. Examples of such themes include the concept of the therapeutic community and the realization of the dangers of overcrowded and impersonal chronic-stay institutions; the idea of isolating the social and physical factors that place a segment of the population in danger and of then attempting to protect the mental health of that group; and the concept of after-care, to name a few. The emphasis throughout is on "the recurring concern with the environment in the prevention and treatment of mental illness."

212. **Cappon, D. (1970). The present status of prevention in psychiatry.** ***American Journal of Psychiatry, 126,*** **131-133.**

The author briefly discusses prevention in psychiatry, beginning at the time when "Pinel and Dorothea Dix were changing the social and medical status of the insane." He states that, thus far, achievements to prevent mental illness have not been great, and psychiatry's involvement in the community mental health movement is "doing the same old thing under a different rubric." Focusing on mental health, however, can allow the development of new and innovative techniques relating to system intervention and social action. Doing so, however, requires a reorientation of attitudes and methodology within the profession and an effort to integrate psychiatry with other disciplines.

213. **Carstairs, G.M. (1958). Preventive psychiatry—is there such a thing?** ***Journal of Mental Science, 104,*** **63-71.**

The tasks of preventive psychiatry, according to this author, can be expressed as either the absence of recognizable mental illness, or as the realization to the fullest possible extent of a citizen's personal potentialities. Recognizing the first to be the more practical, the author poses the question of whether preventive psychiatric measures actually exist. He points out that both preventive medical and preventive social measures have contributed to the prophylaxes of psychiatric disorders, but finds only a limited number of measures that are clearly "psychiatric" in nature. The author identifies three such preventive measures: (1) where the essential etiological factors of a disease are known, timely intervention may prevent their occurrence; (2) effective treatment, applied early, may limit the development of illness; and (3) treatment of established illness can be designed to alleviate the disabilities that it entails. The author further suggests that a critical need exists for additional preventive psychiatric measures.

214. **Eisenberg, L. (1961). The strategic deployment of the child psychiatrist in preventive psychiatry.** ***Journal of Child Psychology and Psychiatry, 2,*** **229-241.**

The number of professionals trained to deal with childhood mental disorder is quite small in comparison with even conservative estimates of need. The deployment of those professionals for both preventive and therapeutic services is thus an important matter. A review of the literature indicates that certain metabolic disorders, birth complications, and maternal deprivation---all of which may lead to serious mental disorder--may be dealt with in such a manner that psychopathology may be prevented. The literature is in less agreement about the effects of psychotherapy with children, but the author cites several studies that demonstrate varying degrees of efficacy, depending upon the diagnosis of the disorder. The findings suggest that: (1) the child psychiatrist in a diagnostic-consulting role can facilitate the work of other mental health professionals; (2) brief psychotherapy may be as effective as long-term therapy for childhood neuroses; and (3) psychiatrically supervised treatment programs might effectively be introduced into institutions to deal with the behavior of delinquents. While the knowledge exists that could reduce the incidence of mental disorder, it is necessary to change the methods and patterns of practice currently employed, and there should be a campaign by mental health workers for social action to modify adverse environmental factors.

215. Flach, F.F. (1972). Community hospitals, psychiatry, and illness prevention. *Psychiatry in medicine, 3*, 99-104.

The community hospital is a uniquely well-suited setting for programs of preventive psychiatry. As an information center as well as a service center, it affords an opportunity for the psychiatrist to come together with other members of the medical community to initiate programs that not only will foster earlier diagnosis and more adequate treatment of psychiatric syndromes, but also will achieve other important goals as well. Whether dealing with children, adults, or families, all members of the health profession can establish effective programs to strengthen the individual's ability to cope with predictable stresses, thereby reducing the likelihood of emotional decompensation. For this purpose, changes of attitude and approach are required within the hospital group and in the relationship between the health profession and the community. (Author abstract)

216. Janssen, E.T. (1977). Prevention requires partnership. *Psychiatric Forum, 7*, 39-44.

This paper calls for a partnership between the psychiatrist and all the forces of a community--parents, teachers, industrial leaders, members of the medical specialties, elected community leaders, clergy men and women, and legislators--to help prevent mental illness. These persons are in a position to recognize the early signs of mental or emotional illness in their domains and often are also in a position to help. An example given is that of industrial leaders who have established programs within the workplace to help employees suffering from alcoholism. ©APA.

217. **Klemes, M.A. (1955). The psychiatrist in industry: A preventive approach. *Industrial Medicine and Surgery, 24* 127–130.**

It is suggested that the psychiatrist's role in industry can and should go beyond the traditional one of consultation and therapy. It is stated that psychiatrists could be most effective by concentrating on preventive programs, either working on them directly or helping organizations set them up. Such programs would affect more people than could be treated with traditional individual approaches and would help avoid problems, rather than waiting for them to occur and then addressing them. In particular, it is suggested that psychiatrists implement "human relations" programs in organizations. The main goals of such programs would be (1) to improve the effectiveness of the many individuals in industry who deal with problems in interpersonal relations, and (2) to help "normal" people adjust to the vicissitudes of industrial settings and deal with the inevitable problems that arise before they cause emotional difficulties. Suggestions are made for laying preliminary groundwork for such programs. It is concluded that even minor changes in industrial environments resulting from such programs can have considerable impact on the emotional well-being and productivity of those directly and indirectly involved.

218. **Kubie, L.S. (1959). Opinions and issues: Is preventive psychiatry possible? *Daedalus, 88*, 646–668.**

In answer to the question: "Is preventive psychiatry possible?" the author responds affirmatively. Implementation of effective prevention involves several things: (a) a more precise knowledge of the psychological development of the human infant, (b) application of methods to correct and reverse the neurotic process in its early stages, (c) the development of new educational techniques, and finally, (d) a critical reexamination of the influences all cultural institutions exercise on the evolution of the neurotic process.

219. **Lindemann, E., & Dawes, L.G. (1952). The use of psychoanalytic constructs in preventive psychiatry. *Psychoanalytic Study of the Child, 7*, 429–448.**

This article begins with an emphasis on the importance of developing working relationships among psychoanalysts, epidemiologists, and social scientists. The Wellesley project is then described as an example of preventive psychiatry. Assumptions behind the project are described as emphasizing the systems of human relationships, with less emphasis on intrapsychic processes even though they are of obvious importance in determining aspects of interpersonal relationships. Efforts of consultation, collaboration, and involvement with families are outlined, and research into crisis theory and developmental crisis in children is described. Particularly in their work with children, psychoanalytic formulations of aspects of child development are stressed as forming the basis for understanding children's reactions to varied transitions and crisis, though differences between clinics devoted to therapeutic interventions and the community-oriented Wellesley project are noted.

220. **Mendel, W.M. (1971). Leisure: A problem for preventive psychiatry.** ***American Journal of Psychiatry, 127,*** **1688-1691.**

The increased amount of leisure time created by a shrinking work week has created conditions that may lead to psychological depression. The work-oriented ethic, which is antipleasure, antileisure, and antilaughter, is perpetuated by childrearing practices and educational systems. Preventive psychiatry requires change in these practices and systems in order to prevent an epidemic of depression in the next two decades. (Author abstract modified)

221. **Messner, E. (1973). Political Psychiatry: The psychiatrist in elective public office.** ***American Journal of Psychiatry, 130,*** **283-285.**

The experiences of a psychiatrist elected to a public office in his town are used to show that elected public officials encounter numerous opportunities for action favoring prevention of psychiatric disorders and the promotion of mental vigor. Preventive measures are described as compatible with and usually exemplifying the discharging of the duties of public office thoroughly and effectively. (Author abstract modified)

222. **Philips, I. (1983). Opportunities for prevention in the practice of psychiatry.** ***American Journal of Psychiatry, 140,*** **389-395.**

The situations of the hospitalized mentally ill parent and of the children of depressed or divorced parents provide opportunities for preventive psychiatric intervention. The case of a 29-year-old woman with three children, who was hospitalized for a borderline personality disorder and delusional symptoms, shows how the neglect of the family exacerbates the patient's symptoms and places the children at risk for developmental and personality disturbances. However, the intake procedures of most institutions fail to consider the effects on the children of the hospitalization of a parent. The depressed mother is likely to be less involved with her children, show a lack of affection, and be guilty or resentful, placing the children at risk for depression or another form of psychopathology. Preventive intervention is also indicated in families of divorce, to which the practitioner can provide counsel and direction to lessen conflict, overcome the "reactive depression" common in children following parental divorce, and help the family deal with the social and psychological changes accompanying divorce. ©APA.

223. **Roberts, C.A. (1971). Primary prevention of psychiatric disorders. In L. Levi (Eds.), *Society, stress, and disease* (Vol. I, pp. 369–388). Cambridge: Oxford University Press.**

This article discusses the role the field of psychiatry should play in the primary prevention of mental disorders. The author discusses various aspects of the knowledge base behind prevention and briefly touches on public policy concerns related to the prevention of a variety of psychosocial problems.

224. **Rubin, B. (1972). Community psychiatry in the decade of the '70's. *Current Medical Dialogue, 39*, 742–746.**

It is asserted that during the 1970s, more and better community mental health, including community psychiatry, must be delivered. Public health concepts of primary, secondary, and tertiary prevention are used in an attempt to carefully delineate the kinds of prevention available in the treatment of the mentally ill. Consultation, once heralded as the answer to primary prevention, has offered little evidence that it prevents the appearance of mental illness or provides greater understanding of its etiology. Secondary prevention has seen the shift of the locus of care from State institutions to the community and community hospital. Tertiary prevention is alleged to be an unglamorous area of psychiatry that has never caught on. It is asserted that the area of social action has been the source of much confusion in community psychiatry.

225. **Schecter, M.D. (1970). Prevention in psychiatry: Problems and prospects. *Child Psychiatry & Human Development, 1*, 68–82.**

This article reviews the literature on problems of childhood and adolescence that present themselves to psychiatry, and considers that, traditionally, psychiatry concerns itself with the amelioration of behavioral and emotional symptoms. Since mental illness occupies more hospital beds than all other illnesses combined, its traditional role of treatment of mental illness is understandable. However, because of new methods of correlating genetic, intrauterine, environmental, and interactive factors, there seems to be what might be considered preventive modes, thereby establishing new therapeutic models. ©APA.

226. **Somers, A.R. (1977). Accountability, public policy, and psychiatry. *American Journal of Psychiatry, 134*, 959–965.**

The author discusses the direction of changes in health policy in the United States that need to be taken into account by the health professions in their dealings with government. Three areas that call for adjustment on the part of the medical profession and major health care institutions are described, and the special challenge to psychiatry implicit in the changes examined. It is concluded that the public's need for attention to the psychosocial aspects of health and the renewed interest in prevention present psychiatry with an opportunity to provide leadership in health care delivery. ©APA.

227. **Wing. J.K. (1980). Innovations in social psychiatry. *Psychological Medicine, 10*, 219–230.**

Within the context of medical and social aspects of treatment, care, and prevention, innovations in social psychiatry in the past 40 years are examined. The chief innovations have been made in the caretaking system for the mentally disabled toward a more open, but looser and less coordinated, system of small units managed by a multidisciplinary staff. New emphasis in community care, both residential and day care, have been coupled with increased attention to rehabilitative strategies and self-help. In the area of less severely disabling orders (neurotic, depressive, and anxiety states), efforts are being directed toward an understanding of how physical, social, and personal variables interact to produce distressed states. Prevention of more severe disorders is also a topic of increasing interest. Methodological advances have also occurred in the measurement of social factors such as life events, emotional expression, and social relationships, and in the evaluation of service delivery systems aimed at improving services and planning. Further innovations are now needed that will lead to the development of a responsible, integrated, and comprehensive mental health service. (Author abstract modified)

See also: 28, 33, 69, 83, 98, 99, 122, 125, 130, 145, 282, 508, 522, 636, 717, 774, 855, 888, 978, 986, 988.

C. Social Work — Social Workers

228. **Deschin, C.S. (1968). The future direction of social work: From concern with problems to emphasis on prevention. *American Journal of Orthopsychiatry, 38*, 9–17.**

The history of the relationship of social work to social influences is described, with one primary dimension of the ebb and flow involving the degree of emphasis on prevention vs. remediation activities and the related emphasis on social reform activities. The wedding of social work theory and practice to the use of psychoanalytic formulations is mentioned as one factor leading social work during World War II to "abandon the poor" in favor of providing service to the middle class. The tension between the historic values of the field and current practice has led to a state of uneasiness. One issue is whether or not social work can become an autonomous profession, not dominated by medicine. Another dilemma involves the role of the profession in social reform and social service, and the profession is described as currently uncertain about its willingness to enter the arena of social reform. New approaches that go beyond psychoanalytic theory and explicitly look at behavior and its adaptive aspects in context are mentioned, and the author challenges the profession to confront its middle-class bias.

229. **Fanshel, D. (1981). Research on preventive services. *Social Work Research & Abstracts, 17*, 2–3.**

Guidelines for research on social and health services aimed at prevention of disorder are offered. It is noted that many concepts in social services have come and gone, and that without solid research efforts, the current emphasis on preventive services may disappear. The importance of the preventive orientation in social work is described in several areas: (1) the elderly person experiencing critical life changes; (2) the young mother assuming parental responsibilties under inauspicious circumstances; (3) the early warning signals of child abuse; and (4) the person in the early stages of mental illness. The need for collaboration between practitioners and researchers is emphasized.

230. **Fischer, J. (1973). *Interpersonal helping: Emerging approaches for social work practice*. Springfield, IL: Charles C. Thomas.**

The author presents a series of readings on the theory and practice of social work and on new developments in preventive intervention, therapeutic intervention, and intervention with the poor. ©APA.

231. Geismar, L.L. (1969). *Preventive intervention in social work*. Metuchen, NJ: The Scarecrow Press.

This book is designed to further the notion of preventive services as an integral part of social work practice, using interventions with young families as an example of how to concretize the more abstract notion of prevention. First, the concept of prevention and its application to social work is discussed. Included are comments on the "what," "when," and "how" of prevention. Next, family functioning and its correlates are examined as a basis for developing a model of intervention aimed at preventing family disorganization. These data aid in identifying "at risk" families and serve as a heuristic for developing intervention strategies. Different possible research and intervention strategies based on these data are then explored, followed by case studies that demonstrate preventive interventions at three levels of family functioning--"Near Adequate," "Near Problematic," and "Problematic." Finally, steps in moving from remedial to preventive interventions in social work are described.

232. Gilbert, N. (1982). Policy issues in primary prevention. *Social Work, 27*, 293–297.

The author analyzes three policy issues that pose limits to the practice of primary prevention in social work: the identification of clients, the unanticipated consequences of intervention, and the profession's capacity to develop and implement preventive measures. The use of universal criteria such as stressful life changes to identify populations at risk ignores the degree of risk, and intervention on such a basis may undermine natural coping mechanisms. Careful experimentation is required to transform tentative social science findings and plausible theories into effective primary prevention programs, and planners must ascertain that the professional standards and levels of effort can be maintained when the technology of pilot projects is transferred to regional or national settings. ©APA.

233. Matus, R., & Nuehring, E.M. (1979). Social work is primary prevention: Action and ideology in mental health. *Community Mental Health Journal, 15*, 33–40.

The role of social work in primary prevention is examined. Data are from a survey of three community mental health centers in which professional staff completed the Gottesfeld Critical Issues of Community Mental Health questionnaire, a time distribution form, and a prevention questionnaire. In addition, all staff working in primary prevention were interviewed in depth. Results show that social workers do more primary prevention and are more experienced in it than their professional colleagues in other disciplines.

They do not, however, conceptualize these activities as preventive and do not particularly embrace a preventive ideology.

234. Radin, N. (1975). A personal perspective on school social work. *Social Casework, 56*, 605–613.

The role of the school social worker is examined, stressing that the major goals are (1) to promote maximum development of all children in a given school, especially those whose potential has been grossly unrealized, and (2) to facilitate optimum preparation of students for future roles in society. To achieve these goals, workers must consider variables hindering development of the group rather than that of a single child. They are thereby forced to deal with social organization factors, curriculum issues, classroom management problems, and policy concerns, as contrasted with the intrapsychic functioning of the individual student. It is noted that the social worker must identify major sources of school problems facing groups of children, such as racial or ethnic differences between students, and deal initially with emergencies caused by child abuse, suicide attempt, school phobia, or death of a parent. It is concluded that the social worker must serve as ombudsman and advocate for the child, especially those from hard-to-reach populations who may require preventive intervention or additional motivation to develop to their full capability.

235. Rapoport, L. (1961). The concept of prevention in social work. *Social Work, 6*, 3–12.

The concept of prevention and its applicability to social work is outlined in this article. First, various definitions and dimensions of the term "prevention" are described, and its central role in public health stressed. Next, problems in moving from the abstract notion of prevention to more concrete preventive functions are discussed, and the importance of a narrow rather than overly inclusive definition is stressed. Various "myths" associated with the idea of prevention are then presented, including the myth that preventive work is easier than working with those having a well-developed pathology, and the myth that one must know the etiology of a specific disorder in order to prevent its onset or spread. Several implications for social work practice are then discussed and examples are given of ways in which social work can contribute to prevention efforts.

236. **Reinherz, H. (1979). Primary prevention in community mental health: Holy grail or empty vessel? In A. Katz (Ed.), *Community mental health: Issues for social work practice and education* (pp. 79–91). New York: Council on Social Work Education.**

This chapter presents origins of the powerful but controversial idea of primary prevention and its application for social work practice and education by tracing the definition of the concept from its beginning in public health theory. The current state of social work knowledge and practice in primary prevention is described. Specialized skills utilized in preventive programs, including consultation, education, and utilization of networks of familial and community resources, are highlighted. The implication of these programs for vulnerable groups, including children and minority groups, is presented. Finally, specific recommendations are made for social work practice and education supportive of the positive value of primary prevention as a mental health goal and professional activity. (Author abstract modified)

237. **Roskin, M. (1979). School social work and primary prevention: Integration of setting and focus. *School Social Work Quarterly, 1*, 31–44.**

As school social work practice shifts away from a clinical, individual, treatment orientation, it is increasingly integrating primary prevention foci and technologies. Factors fostering this integration are explored, emphasizing future directions, major issues, and how school workers may apply and utilize specific primary prevention strategies. (Author abstract)

238. **Roskin, M. (1980). Integration of primary prevention into social work practice. *Social Work, 25*, 192–196.**

The concept of primary prevention is examined, along with the factors that favor or militate against the integration of this concept into social work practice. Factors contributing to potential integration include the evolution of social welfare interventions, current research on life changes involving significant stress and ensuing illness, the growing acceptance of a comprehensive network of personal social services, and treatment approaches readily adaptable to a primary prevention focus--the behavioral approach, the task focused approach, and variations in psychodynamic ego psychology. The dominant factors opposed to integration include financial disincentives, traditional professional training, maintaining the status quo, and the lure of private practice. Current political realities and the possibility of Federal funding for primary prevention projects are also addressed.

239. **Sheridan, M.S. & Johnson, D.R. (1976). Social work services in a high-risk nursery. *Health & Social Work, 1*, 86-103.**

Reasons for placing a social worker on the team of a neonatal intensive care nursery include helping parents cope with crises that arise with high-risk births, ameliorating staff stress, and taking the opportunity to play a preventive role in the followup of high-risk babies. Feelings of guilt may ensue following a high-risk birth, and it is only after these feelings are dealt with that the parents can accept the child they have produced. High-risk births can cause family and marital stress, and when there are concomitant social problems (drug addiction, mental illness, and poverty), the social worker is greatly needed. Even if it is not feasible to follow the family personally, the worker can continue to help the family find available resources.

240. **Sundel, M., & Homan, C.C. (1979). Prevention in child welfare: A framework for management and practice. *Child Welfare, 58*, 510-521.**

The concept of prevention in the social services is examined, focusing on application to the child welfare services, including a primary component from the public health model of prevention. Reasons for mounting interest in prevention from Federal and State legislators, social service administrators, and courts are discussed. A schema adapting public health concepts of prevention to child welfare service activities is provided. Implications of such a model for management and practice are discussed. The problems involved in measuring impact of such programs are noted and the public acceptance and financial support for such programs are considered.

241. **Wershow, H.J. (1977). Setting priorities in health services. *Health & Social Work, 2*, 6-24.**

The argument that the determination of priorities in the area of health services should be done on a rational basis is presented with an emphasis on the importance of primary prevention. The role of social work in social welfare is discussed with reference to the idea that social workers should establish their competence to seek limited, attainable goals. It is suggested that choices made in the allocation of resources should be based on fundamental community-wide services to support and strengthen individual and group functioning, instead of on the present basis, which emphasizes the provision of individual and often esoteric treatment, most of which is expensive and of benefit to few people.

242. **Wittman, M. (1961). Preventive social work: A goal for practice and education. *Social Work, 6*, 19–28.**

The author contends that the need to develop a conception of preventive social work has not yet been squarely faced by the profession. The general concept of prevention as now known is discussed and some of the applications of prevention in other fields are reviewed. The accepted structure for a social service rests upon the conceptual formation of diagnosis and treatment. An alternative based on study, control, and prevention has been adopted in public health practice, and some of the preventive gains in this area are most dramatic. The author contends that the latter conceptual framework must be employed by the social work profession, using knowledge developed in related fields. What preventive activity social work does engage in is traditionally denoted to secondary and tertiary prevention; this does result in some acceptable accomplishments, but it will not bring us closer to long-range solutions of old social problems. It is proposed that social work can contribute at the primary level, provided there is a shift away from providing services to the disabled alone. A shift in educational emphasis in social work training programs is also required.

243. Wittman, M. (1976). *Preventive social work*. Washington, DC: U.S. Government Printing Office.

In this seven-page booklet, a brief history of prevention as it relates to social work practice and theory is outlined, and it is proposed that a sector of effort entitled "preventive social work" has a rationale for application within the discipline. A definition is suggested and a variety of issues relating to prevention and preventive intervention are elaborated. The interface of prevention with major fields of social work practice is also explored. It is contended that a high order of knowledge about child development and growth exists and could be used by teachers, parents, and others at strategic times to assist in promoting positive and avoiding negative life experience. Critical points, such as the prenatal period, might be used for anticipatory guidance. School entrance and early school years are seen as target points for special intervention. Future preventive social work should represent an organized and systematic effort to apply knowledge about social health and pathology to enhance and preserve the social and mental health of the community.

244. Wittman, M. (1977). Application of knowledge about prevention in social work education and practice. *Social Work in Health Care, 3*, 37–47.

The status of preventive social work in the United States is reviewed in the context of public health, mental health, and social work knowledge in social work education and practice. Literature, current issues and concerns, and social work training in the public health, mental health, and social work fields of prevention are cited. The implementation of prevention in education is discussed. Prevention and social work practice are examined within the widening service parameters of the community mental health movement. New directions in social service delivery emerging in response to Public Law 94-63 of the Community Mental Health Centers Act dealing with deinstitutionalization are also considered.

245. **Wittman, M. (1980). The challenge of primary prevention to social work: Past, present and future directions. In H. Staulcup (Ed.), *Primary prevention in social work* (pp. 17–30). St. Louis, MO: Washington University.**

Primary prevention in social work is addressed in the context of the major issues confronting social work educators and practitioners. The history of prevention in social work is reviewed, health and mental health aspects of primary prevention are delineated, and schools that offer primary prevention in the master's level social work curriculum are cited. The theoretical and philosophical concepts underlying the development of practice are assessed, the common criticisms and reservations are reviewed, and the trends and prospects for future development of primary prevention in social work are suggested. The author offers some general comments on field instruction and theory development in the area of preventive social work in view of the fact that the George Warren Brown School of Social Work is one of the first to undertake a Master of Social Work program in prevention.

See also: 103, 500, 519, 693, 790, 891.

D. Nonpsychiatric Physicians

246. **Brill, H. (1965). Mental health. In H.E. Hilleboe, & G.W. Larimore (Eds.), *Preventive Medicine* (2nd edition, pp. 210–227). Philadelphia: W. B. Saunders.**

This article addresses prevention in mental health as it relates to the daily practices of physicians. The author first briefly discusses the history of preventive psychiatry. A discussion of advances in the prevention of mental retardation is given along with developments in the field of pediatrics, which now places greater emphasis on the proper development of personality in infancy and childhood. Issues and advances in secondary and tertiary prevention involving physicians are finally listed. The article addresses some topics of relevance to primary prevention but focuses more heavily on secondary and tertiary preventive efforts.

247. Caplan, G. (1959). Practical steps for the family physician in the prevention of emotional disorder. *Journal of the American Medical Association, 170*, 1497–1506.

The potential preventive aspects of a physician's job are discussed. The physician is described as being one of the key community workers who has contact with people when they are in a state of crisis. Specific intervention situations for the family physician are preventing or minimizing the separation of mother from the family circle; helping the father take over the maternal role left vacant by the mother; anticipatory guidance during pregnancy and/or abortion; and helping patients during bereavement. The need for consultations with psychiatrists for more effective understanding and management of these situations is also discussed.

248. Caplan, G. (1964). The role of pediatricians in community mental health (with particular reference to primary prevention of mental disorders in children). In L. Bellak (Ed.), *Handbook of Community Psychiatry and Community Mental Health* (pp. 287–299). New York: Grune & Stratton.

This chapter begins by providing a definition of primary prevention and the prerequisites for healthy mental development, including physical supplies, psychosocial supplies, and the influence of sociocultural factors. A variety of types of intervention goals are then described, including increasing the capacity to resist stress and designing programs of "anticipatory guidance." The role of the pediatrician is then outlined and its appropriateness for numerous primary prevention roles described. Included are preventive interventions in families; the interaction of the pediatrician with other community caregivers such as nurses, obstetricians, and the clergy; and the role of the pediatrician in influencing both agency policy and social action. It is stressed that the intent is not to transform pediatricians into psychiatrists, etc.; rather, the intent is to stimulate a wider range of activities consistent with the role of the pediatrician.

249. Cecil, H.S. (1970). Child development and pediatric office practice. *Delaware Medical Journal, 42*, 176–182.

The management of child development problems in the pediatrician's office is discussed, with particular attention paid to those problems arising in the first 2 years of life. The ability of the doctor to intervene meaningfully depends on a good relationship with the family and also on a respectful, nondeceptive relationship with the child. Since the pediatrician is involved with developmental issues so early in the child's life, he has the unique opportunity to practice preventive mental health. Strictly speaking, very young infants (birth to 9 months) have no psychological problems, but they often show subtle signs related to their psychological development. The key to diagnosis and management lies in an examination of the mother's caretaking behavior and her attitudes and reactions to the baby's temperamental patterns. Deprivation syndromes may be involved; these disturbances are more difficult to manage. At 9-18 months old, negative and self-comforting behavior may be present. Skill in family history-taking is essential for diagnosis and treatment. Information regarding the child's primary reactive patterns is important since under normal conditions an infant probably tends to become stabilized in such behavior. Support to the family may sometimes be enough to bring improvement. The wise physician must evaluate the direction of family integration and refer this patient, if necessary, to an appropriate children's psychiatric service before disorders become fixed and chronic.

250. **Hilleboe, H.E. (1972). Modern concepts of prevention in community health. *American Journal of Public Health, 61*, 1000–1006.**

Prevention in the area of community health is focused "on groups of individuals, formed into a community, whose members face common health problems among whom an organized community effort is essential for their resolution." Full knowledge of cause is not necessary before action is taken. Attention is thus focused on steps the physician can take in the service of prevention, and includes both interventions with individuals (e.g., help retired persons adjust to their leisure years) and community actions (e.g., take part in postgraduate education programs that highlight preventive aspects of practice). The importance of educating politicians and the public about preventive issues is noted, and administrative research in the application of preventive measures is cited as important.

251. **Jensen, A.R. (1955). The physician's role in preventive mental health services. *American Journal of Psychiatry, 3*, 857–861.**

This article argues for an emphasis on prevention in the mental health field. It is suggested that the focal point for a concerned effort be children, their development, and parent-child relationships. It is also suggested that physicians who deal with children be at the center of this effort. It is argued that physicians have been central to all effective prevention programs in health-related areas. Advantages of using physicians are their large numbers, the large number of existing resources such as offices, and assured interactions between young children, parents, and physicians. Suggestions are made as to how and in what areas physicians could function as an educational and preventive force. These range from parent education about the nature of children, to recognizing and allaying anxiety in both parents and children, to giving support during periods of parental stress, to assistance of and early discussion with parents of handicapped and mentally retarded children. It is stated that as the physician recognizes and addresses his/her role in parent education, parents will be more effective in childrearing.

252. **McKerracher, D.G. (1968). The general medical practitioner. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders* (pp. 145–149). Toronto: University of Toronto Press.**

The author states that primary prevention of mental disorder must become a regular part of the work of nonpsychiatric physicians, especially the general practitioner. Each day physicians see a large number of people whose illnesses also have components of anxiety, depression, or confusion. About one-third of patients seeing a general practitioner have no somatic problems--only anxiety or depression. The general practitioner must learn to recognize and deal with anxiety and depression as early signs of decompensation. Many techniques of educating physicians have been used: lectures, refresher courses, and seminars. The author reports on a program that allows general practitioners to treat their own pyschiatric patients in hospitals, with the assistance of psychiatrists as consultants. This familiarization with psychiatric practice will provide physicians with the competence to intervene before psychopathology has had a chance to flourish. Such experience may also be fruitfully incorporated into the psychiatric experiences of medical students.

253. **Richmond, J.B. & Tipton, E.L. (1961). Studies on mental health of children with specific implications for pediatricians. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 95–121). New York: Basic Books.**

The evolution of pediatric practice and its growing concern with the primary prevention of mental disorders of childhood are presented. Protection of physical health and of the growth of the central nervous system are viewed as the traditional preventive role of pedatrics. Research on patterns of autonomic function and the effects of parental separation at various developmental stages are summarized. The difficulties in teaching and research in the areas of parent-child interaction and doctor-family interaction are discussed. As the field continues to develop, it is suggested that doctors must continue to rely on educated judgments concerning the psychological and social situations of families in their treatment of patients.

See also: 69, 99, 129, 130, 517, 726, 991.

E. Religion — Ministers

254. Clinebell, H.J. (1976). Positive prevention: Implications for ministry. *A.M.H.C. Forum, 23*, 114–119.

A human growth orientation emphasizing human potential is proposed for the ministry. The growth perspective is a set of theoretical assumptions about the nature of being human that is posited as more appropriate for the clergy than the pathology model. The growth perspective views health as the full use of one's resources or potentials and assumes that positive mental health is more than the absence of illness or gross pathology. It is suggested that the growth model provides for the clergy a strategy of positive prevention that can be accomplished by nurturing people in their normal relationships and in keeping good relationships well. By focusing on the present and future, on strengths and potentials, and on responsible decisions, the growth model is seen as a means of helping troubled people through times of personal crisis.

255. Snyder, J.A. (1970). Clergyman in a preventive mental health program. In H.J. Clinebell (Ed.), *Community mental health: The role of church and temple* (pp. 77–81). New York: Abington Press.

The author stresses the need for cooperation between psychiatry (and its allied professions) and the clergy in furnishing primary preventive care. It is suggested that the ministry can provide unique contributions to such services.

256. Uomoto, J.M. (1982). Preventive intervention: A convergence of the church and community pschology. *Journal of Psychology and Christianity, 1*, 12–22.

This paper argues that the church can be a potent resource in addressing mental health needs. Primary preventive efforts through deficit-prevention competency building strategies, social systems interventions, and the fostering of a healing theological climate are discussed. Persons implementing preventive strategies within the church must consider "right models" and "divergent" solutions in order for primary prevention to be effective. ©APA.

257. **Whitlock, G. E. (1973). *Preventive psychology and the church*. Philadelphia: Westminister Press.**

The article describes a new model of pastoral counseling with increasing emphasis on prevention. Practices of crisis intervention are described. Community involvement in mental health and collaboration with mental health professionals are advocated. ©APA.

F. Miscellaneous Professionals

258. **Banikiotes, P.G. (1973). A preventive approach to mental health in the schools.** *Counseling and Values, 17*, 112–117.

The author discusses the advantages and disadvantages of having the school counselor reorient his function from mainly corrective to mainly preventive aspects in elevating the quality of mental health in the community. ©APA.

259. **Caplan, G. (1981). Partnerships for prevention in the human services.** *Journal of Primary Prevention, 2*, 3–5.

The role of mental health professionals in the programs of other community health and service agencies is briefly addressed. It is contended that such professionals must often work outside the walls of their own specialized institutions and must develop partnerships with administrators and staff of the community agencies. This development is seen as reflecting increased interest on the part of leaders in the fields of medicine, education, welfare, and religion for including psychiatrists and psychologists in their programs. It is concluded that the specialized contribution of the mental health professional to the partnership involves the treatment and prevention of psychopathology via consultation and direct interactions with clients in the community facility.

260. **Daws, P.P. (1973). Mental health and education: Counseling as prophylaxis.** *British Journal of Guidance and Counseling, 1*, 2–10.

Although school counseling is concerned primarily with prevention rather than cure, in practice the urgent needs of disturbed children leave little time for genuinely preventive work. Effective prophylaxis in the strong sense of laying foundations of robust mental health, competence, and well-being in all children must involve the whole school to some degree. However, most important is a team of interested capable teachers working with the school counselor on curriculum development in personal and social education. Though the needs of the few can be met by one-to-one counseling, the needs of the many will be answered only through group work. Trained counselors must take the initiative in such work and not allow their colleagues the complacence of feeling that the appointment of a school counselor is an ample school contribution to the objectives of preventive psychiatry. ©APA.

261. Ellsworth, P.D. (1980). Community organization and planning consultation: Strategies for community-wide assessment and preventative program design. *Occupational Therapy in Mental Health, 1*, 33–35.

The role of the occupational therapist as a consulting health agent with resultant responsibilities for participation in health planning and preventive program development is discussed with reference to an Army community mental health program targeted at improving the quality of military family life through provision of a network of services. Included is a consideration of community problem-solving methods, an overview of community organization, and the principle of preventive intervention. A community-wide assessment methodology on which to base planning decisions is presented. The principles of prevention, community assessment, and occupational therapy program development are emphasized through a discussion of the mental health model that evolved in the military community. (Author abstract modified)

262. Evans, F.M.C. (1971). *Psychosocial nursing: Theory and practice in hospital and community mental health*. New York: Macmillan.

This book focuses on primary prevention action and emphasizes the holistic view of man. Identification of the patient's strengths and an assessment of his coping deficits are discussed as important considerations in the nurse-patient relationship. Aspects of human development and crises of life are reviewed to provide the nurse with a yardstick to measure mental health. Stress, loss, aggression, suicide, and withdrawal are covered.

263. Finn, G.L. (1977). Update of Eleanor Clarke Slagle Lecture: The occupational therapist in prevention programs. *American Journal of Occupational Therapy, 31*, 658–659.

The past, present, and future role of the occupational therapist in prevention is examined. The increasing emphasis on community-oriented services delivery in the 1970s expanded the role of the therapist to one that required a knowledge of socioeconomic and political factors influencing health programming, sociobehavioral dynamics, the significance of occupational performance in human development and adaptation, and interpersonal and communication processes. Since then, occupational therapy has expanded further into the community in the areas of primary, secondary, and tertiary prevention, primarily in the form of early intervention programs to allay development of more severe dysfunctions among high-risk populations, and in the rehabilitation of the institutionalized into the community. In the future, it is suggested, occupational therapy should direct itself to more comprehensive primary prevention, including goal-directed use of time, energy, interest, and attention to mental and physical health.

264. Goldman, E. (1972). *Community mental health nursing: The practitioner's point of view*. New York: Appleton-Century-Crofts.

A report of a conference sponsored by the American Nurses' Association is divided into three sections: current innovations in community mental health nursing practice, theoretical explorations, and the conference model. The first part presents discussions on current practices in meeting the mental health needs of clients. The conventional approach to psychiatric illness is not used; instead, emphasis is placed on primary prevention and identifying the environmental, physical, and psychosocial aspects of a community that serve as deterrents to mental health. The second part deals with theoretical conceptualizations of the issues raised in the first section as they involve planning mental health services, the use of power in planning these services, and the concept of change in community mental health practice. The last part presents the model used for the conference, including the grant proposal, conference process themes, and issues of community mental health nursing, recommendations, and evaluation. The participants and speakers at the conference were professional community mental health nurses from all sections of the country. The purpose of the conference--a description of the nature and scope of community mental health practice and problems--and a review of new and innovative forms of practice are included.

See also: 5, 57, 58, 59, 69, 73, 273, 509, 535, 756, 873, 982.

IV. Early Intervention

Intervention early in the human life cycle is a frequently discussed and researched strategy in the primary prevention of psychopathology. Articles within this category are broken down into various subsections: (1) articles that argue the merits of early intervention, review programs and research in this area, or contribute to its knowledge base, (2) articles that discuss intervention during the neonatal stage of development, (3) articles that discuss general research, screening, and intervention with perceived "at-risk" populations, (4) articles involving Project Head Start programs, which intervene with at-risk children and (5) articles that discuss intervention at an early stage in the life cycle with a population not defined as at risk.

A. Conceptual Review and Opinion Papers

265. **Badger, E., & Burns, D. (1982). A model for coalescing birth to three programs. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 513–537). Hanover, NH: University Press of New England.**

The United Services for Effective Parenting (USEP), an organization that resulted from the bringing together of over 170 grassroots parenting programs in Ohio, is described. In this paper, the authors express their bias against Federally mandated programming, which has had only limited success with translating policy into services, and instead propose a model of organizing and linking community resources from the grassroots up. USEP has resulted in a coordination of local efforts to insure the survival of early intervention programs, personal development, and networking options for program practitioners; coordination and cooperation among programs; program accountability; and improved services to families.

266. **Belfer, M.L. (1979). Postpartum issues in prevention. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 77–86). New York: Basic Books.**

This article first asserts that the post partum period should be viewed in the context of the preceding events of the pregnancy, the parents' approach to it, and various other factors. Thus, the very decision to have a child greatly influences the post partum period and its impact. Next, a variety of post partum psychological disturbances are discussed, including "blues" and transitory depression, reactive depressions, and post partum psychoses, with preventive interventions varying to fit the particular post partum condition. The issue of infant-mother fit is next discussed as a source of potentially maladaptive interaction, and educational efforts that help mothers understand individual differences in children are recommended. Finally, the positive role of well-baby clinics is stressed.

267. **Berlin, I.N. (1972). Prevention of mental and emotional disorders of childhood. In B.B Wolman (Ed.), *Manual of child psychopathology* (pp. 1088–1109). New York:** McGraw–Hill.

The three levels of preventive classifications are individually discussed relative to childhood mental disorders. In considering primary prevention, the anticipation of maternal depression at the times of pregnancy and birth, difficulties in the mother–infant relationship, and early discrimination of organic disability are stressed. Secondary prevention stresses early recognition of symptoms of emotional disturbance and of increased vulnerability. The importance of parent cooperation in remediatory/preventive efforts is noted. The availability of therapeutic services is of prime importance for tertiary preventive programming. Crisis interventive activities are described in relation to primary and secondary prevention.

268. **Berlin, I.N. (1979). Early intervention and prevention. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 135–139). New York: Basic Books.**

This chapter outlines several critical times when preventive interventions seem appropriate: prevention in the prenatal period, early infancy intervention and prevention, preschool prevention and early intervention, learning problems and prevention, school-age intervention and primary prevention, and primary prevention in adolescence. Examples of prevention programs are offered in each of these areas. For example, the important role of nutrition as a prenatal intervention is noted, and various programs designed to support mother–child interaction are included in the section on early infancy intervention. The role of the school as a preventive agent is more prominently stressed as the child grows older.

269. **Berlin, I.N. (1979). Primary prevention. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 14–17). New York: Basic Books.**

This paper outlines some of the implications for primary prevention beginning before the birth of the child and extending through adolescence. Seven times for intervention are cited, including prenatal factors, natal factors, neonatal factors, infancy and the first 3 years of life, the preschool child, the school-age child, and the adolescent. Within each of these time periods, research bearing on preventive interventions is discussed. For example, primary prevention during the first 3 years of life is linked closely to the nurturing process between parents and children, while for adolescence primary prevention "focuses on the identity and individuation struggles that are characteristic of this developmental period." In addition to personal and interpersonal interventions, the author also cites racism as exerting a powerful and negative effect on development.

270. **Blumberg, M.L. (1973). Prophylactic psychotherapy with children. *American Journal of Psychotherapy, 27,* 155–165.**

The author considers that prophylactic psychotherapy with children can prevent emotional ills in later life. It is suggested that parents at various periods may require guidance and encouragement in the proper handling of their children. The view is presented that prophylactic psychotherapy should be applied with variations at each stage of emotional and cognitive development of the child, with modifications being introduced as the child's personality demands and extraneous events dictate. It is concluded that much actual psychopathology could be avoided if prophylactic psychotherapy were applied in handling the child who is basically emotionally healthy. ©APA.

271. **Bolman, W. (1967). An outline of preventive psychiatric programs for children. *Archives of General Psychiatry, 17,* 5–8.**

The author points out the extensive need for services to treat mental disorder and suggests that alternative approaches to this problem must be developed. Recent changes in the approach to mental disorder are noted, such as a new "community approach," an orientation towards people rather than programs, and an emphasis on prevention. He notes, however, that skepticism still prevails regarding the feasiblity of preventive intervention. After surveying the field of prevention, the author notes that little research has been done that documents the efficacy of preventive programs. However, a number of preventive programs exist, serving a wide variety of populations. A conceptual framework (based on public health approaches) and an outline of community-based prevention programs for children are presented. The outline lists specific approaches of primary, secondary, and tertiary prevention involving 15 different population groups. The goals of these preventive interventions and the resources currently available for the provision of services are discussed.

272. **Bond, L.A. (1982). From prevention to promotion: Optimizing infant development. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 5–39). Hanover, NH: University Press of New England.**

Several theoretical approaches to understanding infant development are briefly presented. Conceptualizations of development that consider the infant as an active participant in his/her own growth, with an inherent motivation toward mastery, are stressed. Along with this, the author focuses on the interaction of the infant and the environment, in which the infant influences his/her environment and is in turn influenced by it in a mutual pattern-creating way. It is argued that interventions to promote optimal infant development need to focus on the infant-caregiver dyad, so that effective, growth-enhancing patterns may be established. Also, inteventions at higher levels of the social system are important in that these systems can serve to enhance or impede optimal growth of infants and their parents.

273. **Bower, E.M. (1969). Slicing the mystique of prevention with Occam's Razor. *American Journal of Public Health, 59*, 478–484.**

The focus of this paper is on the "mythologies" and assumptions about mental health and education that have kept attempts at the early identification of children with potential problems feeble and ineffective. One such myth is that the state of a child's mental health is best judged by a mental health professional rather than by less "sophisticated" professional persons who live with the child on a day-to-day basis. It is noted that some previous research has suggested that ratings of students by teachers, peers, and the students themselves could reliably identify children with beginning problems. Professional biases against this view are briefly examined. The author proposes that such biases result from an investment in the myth that it is possible to assess and evaluate behavior or mental health as positive or negative, independent of the social context wherein the individual is living and functioning. Teachers, who focus on observable behavior in school, might be closer to an operational reality of mental health than can be determined in an office examination. The author sees mental health as comprising the kinds of competencies that allow a child to function effectively in these contexts. The author proposes that referral services are no longer desirable or necessary, and that one way to increase the school's ability to serve more children more effectively is to develop mental health professions that would work as active partners directly with the teachers in the schools. Programs of early identification in schools must not only find problem children early, but must also provide for the institutional changes that will enable schools to carry out their goals for greater ranges of children.

274. Bower, E.M. (1972). K.I.S.S. and kids: A mandate for prevention. *American Journal of Orthopsychiatry, 42,* 556–565.

The key integrative social systems (KISS) are those primary institutions that give pattern and meaning to the basic personality of the individual and to the society in which he lives. The field of preventive action is focused on four key areas: (1) health services, especially to prospective mothers and young children; (2) families; (3) peer play arrangements, both formal and informal; and (4) schools. Not all children thrive at all times within the KISS. Some require occasional social first aid, usually as a result of health, family, peer, or school problems. The KISS permit and in some cases encourage the greatest degree of personal freedom and functioning. A family exists to provide children with the best chance of experiencing a mediating adult. The mediating function of the family has always been there, camouflaged by economic, protective, health, and consumer functions. The mediating person in the family is followed by a succession of other mediating persons: relatives, nursery teachers, teachers, and other adults. The teacher is a mediator, cognitively able to expand and to integrate ego processes. It is proposed that a new KISS institution be made available to all children up to the age of eight or nine and their families. It would be an open KISS system in that children could move in and out of various activities in their own style and at their own speed.

275. **Brody, S. (1961). Preventive intervention in current problems of early childhood. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 168–191). New York: Basic Books.**

Observational categories for assessing normal resolution of normal conflict, excessive avoidance of conflict, and compulsive seeking out and sustenance of conflict are presented. It is proposed that guidance programs for parents, based on regular and intensive observations and interviews, be set up in clinics and day care centers or nursery schools for the regular study of a child's developmental progress from birth through the preschool years. Criteria for mental health to be used by evaluating nurses or physicians are suggested. Then suggestions for intervening mental health workers are made. Finally, case studies are used to show how observation and understanding of both dynamic and genetic determinants of a child's immediate emotional state can help to avoid disturbances.

276. **Bronfenbrenner, U. (1974). Is early intervention effective? *Teachers College Record, 76*, 279–303.**

The author reviews the short- and long-term effects of early intervention programs to enhance the intellectual and social development of children. Seven studies are examined and the results are summarized. The programs most effective in producing and maintaining change in the participating children's IQ levels were those in which intervention began very early and a parent training component was included. An ecological model for planning, enacting, and evaluating an intervention program is stressed. The author urges change to be instituted at the levels of society, community, and family in order to successfully help disadvantaged children.

277. **Brown, B. (Ed.). (1978). *Long-term gains from early intervention*. Boulder, CO: Westview Press.**

This edited volume consists of papers presented at a symposium entitled "Found: Long-term Gains from Early Intervention" at the American Association for the Advancement of Science meeting in Denver, Colorado, 1977. The reports review both center and house-based early intervention programs (Head Start) designed to enhance early intellectual and social development of children. The authors cite evidence for late-developing gains in intellectual achievement and emotional adjustment. Early intervention appears to have dramatic effects in the assignment of children to special education classes and on retention in grade. In all, the papers describe 96 major studies that report positive impacts from early intervention programs.

278. **Caplan, G. (1961). General introduction and overview. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 3–30). New York: Basic Books.**

The author sets the stage for his edited book by discussing the concept of prevention and its appropriate place within mental health research and practice. He points out that the fundamental concern of primary prevention is with the identification of populations at risk for mental illness and interventions aimed at reducing the noxious factors leading to this risk. Various factors thought to promote increased rates of mental disorder among children are divided into three categories, including organic, psychological, and social factors. Community-oriented preventive research and action is seen as one component of a comprehensive planning process, rather than as an opposing force to the secondary and tertiary prevention conducted by current treatment programs. Specific areas to be addressed in the remainder of the book are summarized.

279. **Caplan, G. (1961). Concluding discussion. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 398–416). New York: Basic Books.**

The major hypotheses and findings put forth in this edited book are integrated under two main headings insofar as they are designed to deal with two types of pathogenic influence. The first deals with general planning or programming strategies that seek to manipulate the biological, psychological, and sociological forces influencing the development of a population of children. The second deals with individual, situationally focused interventions at crisis times. An integration of a generally acceptable body of knowledge with regard to primary prevention is called for, along with a more politically active approach to obtaining and utilizing community resources on the part of mental health professionals.

280. **Department of Health, Education and Welfare (1979). *Clinical infant intervention research programs: Selected overview and discussions*. (DHEW Pub. No. (ADM) 79-748). Washington, DC: U.S. Government Printing Office.**

This 120-page publication is essentially divided into four sections. The first section gives an overview of clinical infant research programs. Discussion is focused on program design, methods of infant selection into the programs, characteristics of the infant samples, types of intervention methodologies, and program research. The second section gives a historical overview of research relevant to clinical infant intervention. In the third section methodological issues involved in outcome research with early intervention programs are discussed and a framework for assessing these programs is given. Finally, 24 clinical infant intervention research programs that work with high-risk infants under 3 years of age and their families are reviewed. Features of these programs, such as primary focus, whether it be prevention and/or psychological development; selection and characteristics of infants; and intervention methodologies and their effectiveness are delineated.

281. **Earls, F. (1976). The fathers (not the mothers): Their importance and influence with infants and young children. *Psychiatry: Journal for the Study of Interpersonal Process, 39*, 209-226.**

The father-child relationship, specifically as a possible early determinant of behavior deviance in children, is examined through a review of the literature. Three developmental periods are studied in relation to what is known of paternal behavior and its influences: pregnancy, infancy, and early childhood. These studies indicate that five variables influence this relationship: (1) sex-related inheritance; (2) paternal behavior during pregnancy; (3) paternal attachment; (4) paternal discipline; and (5) paternal influence on the adoption of sex-typed behavior of the child. Ways fathers can more actively participate in the prevention and treatment of behavioral problems are discussed. Areas for investigation of how fathers handle intervention techniques are suggested.

282. **Eisenberg, L. (1962). Possibilities for a preventive psychiatry. *Pediatrics, 30*, 815–828.**

The author discusses the possibilities for preventive psychiatry at primary, secondary, and tertiary levels of intervention. With regard to primary prevention, which has often been a misunderstood endeavor, the task is to devise specific methods for preventing particular disorders. Abandoning the unrealistic goal of total mental health, it becomes apparent that we now have the knowledge to prevent a number of disorders. Using the example of the deprivation syndrome in children, the author points out that it may begin at one of several stages of development and that it may adequately be prevented. It may be prevented before conception by proper birth control methods if the mother is in ill health or wants no children. Good maternal nutrition, prenatal care, and alleviation of psychosocial stress may prevent it during pregnancy, while nutrition, medical care, and enrichment of the environment can prevent it after birth. The author also discusses the problems of secondary and tertiary prevention, both important, since total prevention at the primary level is impossible. Much of the reason for the neglect of prevention is to be found in the bias that most psychiatrists have in favor of individual psychotherapy. While psychoanalytically oriented treatment is undoubtedly of value, its present entrenchment is counterproductive to community-based programs of prevention. Social realities demand a revision of this model.

283. **Eisenberg, L. (1969). Introduction-preventive methods in psychiatry: Definitions, principles, and social policy. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 3–8). New York: Basic Books.**

This paper begins by defining and giving examples of primary, secondary, and tertiary prevention. Preventive genetics and social competence in schizophrenia is then discussed as a major area in which genetic counseling is seen as a less useful preventive approach than a variety of strategies designed to buffer the children of psychotic parents against the vicissitudes of family stress. Primary prevention and developmental attrition, the "sequential and cumulative failure to attain levels of cognitive and affective development sufficient for personal and social competence," is then discussed. Here, primary prevention is limited only by the extent of our moral commitment, as relevant knowledge and programs are available in a variety of areas. The need for cognitive and affective nutrients is also cited as an important area for preventive work. The author concludes by asserting that we have the means for primary prevention but have not yet developed the will to devote enough resources to it.

284. Fischer, J. (1975). Screening for the early detection of mental disorders in children. *International Journal of Mental Health, 4,* 107–112.

The author stresses the importance of preventing mental disorders in children, since adult neuroses come as a result of developing incorrect modes of behavior in childhood. Child psychiatry thus becomes a branch of adult psychiatry. A scientific theory of prevention should be based on a knowledge of etiological factors. Prevention has two aspects: guarding against harmful influences and strengthening the child's health. Plans for prevention must be based on knowledge of physiology, psychology, pathophysiology, psychopathology, and infant personality development. The special problems of the slow learner and the unpopular child are described. Other individuals and institutions that should be involved in recognizing the danger signs of early neurosis are school doctors, counseling centers, and the general public. ©APA.

285. Garmezy, N. (1971). Vulnerability research and the issues of primary prevention. *American Journal of Orthopsychiatry, 41,* 101–116.

The author states that the goal of primary prevention of mental disorder is an important one. The data at hand, however, are inconclusive as to how variables such as family and social structure influence the development of psychopathology. Although our understanding of the etiology of mental disorder is limited, there are certain programs that a responsible society should provide: adequate prenatal, postnatal, and infant care; social agencies designed to meet peoples' emotional and economic needs; and so on. Although helpful, such programs are too broad to substantially reduce the incidence of mental disorder. What is necessary is improved research strategies in psychopathology. One direction research should take is vulnerability research with high-risk groups. The author discusses issues in defining the high-risk group and difficulties in the selection of a suitable group of control subjects. Another factor of importance is the choice of variables to be measured. The author suggests that, in their choice of variables, researchers avoid a premature focus on global theorizing about etiology in favor of a search for relevant behavioral parameters that will distinguish high-risk adaptive, high-risk maladaptive, and nonrisk subjects. Finally, it is argued that research should also be conducted with normal children to learn more about the healthy way in which they survive and adapt.

286. **Goldston, S.E., Ojemann, R.H., & Nelson, R.H. (1975). Primary prevention and health promotion. In E. Lieberman (Ed.), *Mental health: The public health challenge* (pp. 51-58). Washington, DC: American Public Health Association.**

Aspects of effective prevention with respect to mental health are discussed. The authors note that primary prevention is the concern of the entire community rather than an exclusive responsibility of mental health workers. A developmental approach to programming in primary prevention should focus on activities related to early child development and increased parental competence, programs devoted to the mental health aspects of public school education, and adolescence. Such programs should be addressed to specific high-risk target groups. For early casefinding, it is necessary to consider populations at risk and screen patients for mental health as they present themselves for general health care. A few principles that should undergird secondary prevention include ready accessibility, prompt assessment of need for therapy, continuity of care, and minimization of institutional confinement.

287. **Goodrich, D.W. (1961). Possibilities for preventive intervention during initial personality formation. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 249-264). New York: Basic Books.**

From birth to 6 years, the child is thought to make several developmental transitions that will shape his or her future adaptation. Thus the aim presented is to ensure that the child's primary experiences with common affect-laden interpersonal issues such as trust, dependence, autonomy, separation, strangeness, cooperative play, and so on be mastery experiences rather than disorganizing failures. Structural and process elements in developmental transitions are used as theoretical frameworks within which preventive action is conceptualized. An intervention through the Biosocial Growth Center at the National Institute of Mental Health is used to illustrate this strategy.

288. Greenspan, S.I. (1980). *Psychopathology and adaptation in infancy and early childhood: Principles of clinical diagnosis and preventive intervention*. Springfield, VA: NTIS.

Patterns of adaptive and maladaptive development in infants, young children, and their families are delineated. A new integrated conceptualization of the physical, cognitive, and emotional development that occurs during the first 4 years of life is introduced. Principles of clinical diagnosis and preventive intervention, with clinical illustrations, are discussed in relation to the framework.

289. Harmon, R.J. (1981). Perinatal influences on the family: Some preventive implications. *Journal of Preventive Psychiatry, 1*, 132–139.

Preventive implications of perinatal influence on the family are considered in a paper presented to the 1979 Symposium on Infant Psychiatry. The Klaus and Kennell (1976) notions about early mother-infant social interactions and bonding are reviewed. Klaus and Kennell view the major influences on maternal behavior in terms of fixed and alterable determinants. Alterable determinants include the behavior of hospital personnel, hospital practice, and the amount of early mother-infant separation. Fixed determinants include the mother's care by her own mother (mother and grandmother relationship), the relationship of the mother with her family and her husband, and experiences with previous pregnancies and/or the planning course and events of the current pregnancy. These fixed determinants are assessed in the light of the relevant literature, and clinical examples are provided to illustrate the dynamics of these interactions. It is suggested that the Klaus and Kennell model provides a useful guide for clinical practice, with implications for both the parental role and child mental health.

290. Honig, A.S. (1982). Intervention strategies to optimize infant development. In E. Aronowitz (Eds.), *Prevention strategies for mental health* (pp. 25–55). New York: Prodist.

This article reviews 12 different types of early intervention strategies designed to optimize mental health development in infants and young children. After a brief description of each of these 12 types, the author discusses several examples of programs within each type. Thus, the first type of early intervention program consists of the provision of a curriculum for infants and toddlers with minimal attention to the teaching of parental skills or principles of infant development to parents. The second type of early intervention programs involves engaging parents as teachers of infants through home visitation by volunteers, paraprofessionals, or professionals. A third intervention strategy focuses on bringing groups of parents together to help them become a treatment resource for their own children. A fourth type involves the placement of parents as workers within child care facilities whereby they can acquire skills and understanding in child development. Drop-in parent-child support services constitutes a fifth type of early intervention program. Other types of early intervention programs are: (1) teaching parenting skills through televised instruction; (2) therapeutic programs in severe cases of neglect or failure to thrive; (3) the use of systematic, regular assessment to monitor infant development and provide feedback to parents; (4) use of existing institutions such as high schools and pediatric outpatient facilities as settings for parental or parents-to-be involvement; (5) use of audiovisual materials with parents; (6) enhancing parent-infant interaction using the Parent Behavior Progression checklist; and (7) early intervention programs that combine many different features into one program.

291. **Lambert, N.M. (1972). Intellectual and nonintellectual predictors of high school status. *Journal of Special Education, 6*, 247-259.**

The prevention and early identification of problem-prone children is discussed. The theory that both intellectual and nonintellectual appraisals of student behavior in elementary school are predictive of high school functioning, as well as high school behavior, is studied. The assumption that nonintellectual behaviors of children can interfere with or promote acquisition of learning and achievement goals and social competence is supported. It is indicated that elementary school grades predict a greater range of high school behavior than measures of intelligence do. It is concluded that more comprehensive assessment of behavior is needed in elementary school to identify children who require special accommodation by the school so as to promote later elementary school and high school functioning.

292. **Lourie, R.S. (1979). Primary prevention for infants. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 17-29). New York: Basic Books.**

Primary prevention for infants is examined with emphasis on the two major components: the developing fetus and the infant, and the environment into which it is born and reared. Examples are given of programmatic approaches that make prevention possible. Topics discussed include: (1) the role of individual constitutional differences; (2) the role of the physical environment and early primary prevention; (3) nutritional considerations; and (4) genetic counseling. The programmatic approaches to primary prevention involve application of child development research to pioneering intervention programs for infants and families oriented toward cognitive development, identification of high-risk babies, and the occurrence of psychopathology in infancy.

293. **Murphy, L.B. (1961). Preventive implications of development in the preschool years. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 218–248). New York: Basic Books.**

Psychological health is viewed as the ability of the infant or young child to maintain internal integration and resilience against stressful experiences. From this point of view, primary prevention must consider the effects of parental stability, family unity, ideology, maternal preparation, ecological and environmental conditions, and pediatric handling. It is suggested that a comprehensive program of primary prevention would involve a discriminating assessment of the sensitivities, imbalances, strengths, and needs of the infant; strengths and blind spots of the caretaker in response to the baby; and other hazards and strengths of the environment in relation to the equipment of the individual child.

294. **Murphy, L.B., & Chandler, C.A. (1972). Building foundations for strength in the preschool years: Preventing developmental disturbances. In S.W. Golann, & C. Eisendorfer (Eds.), *Handbook of community mental health* (pp. 303–330). New York: Appleton-Century-Crofts.**

The authors assert that the coming generation of children will grow into a culture with increasing demands for adaptability to change and a greater need to respect basic human and democratic values. A comprehensive, multidisciplinary approach to development, including the entire situation of the child as an organism in his physical, cultural, and personal or family environment, is needed to maximize the coping resources of the child. Various potential disturbances and failures in development are outlined in detail by the authors. Some operational guidelines for the prevention of disorder and the development of strength during the first 5 years of life are presented.

295. **Palmer, F.H., & Anderson, L.W. (1979). Long-term gains from early intervention: Findings from longitudinal studies. In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 433–466). New York: Free Press.**

Early intervention programs designed to enhance the cognitive abilities of children are reviewed. These studies were begun in the 1960s, and while most of them were not designed as longitudinal, followup data were collected in the 1970s. A few of these studies were specifically concerned with the effectiveness of Head Start programs, but most of them were unaffiliated with Head Start. Data from these studies support the contention that early intervention can improve school performance. Results from these studies are applied to the planning of programs with children, suggesting the need for earlier and longer interventions, involvement of parents in the programs, and the building of broad-based community supports for programs.

296. **Richmond, J.B., & Janis, J. (1980). A perspective on primary prevention in the earliest years. *Children Today, 9*, 2–6.**

A perspective on national primary prevention health care for infants is presented. Data are cited from the Surgeon General's Report on Health Promotion and Disease Prevention, released in July 1979. They indicate that of six major gains in health status achieved within the past few years, four relate to improvements in child health. An important advance is seen in the acceptance of the interactionist nature of the relationship between the individual and the environment. This view recognizes the flexibility of the human organism to adapt to changing life circumstances and focuses on the relationship between the mother and the infant. Parents' behaviors are no longer viewed as being solely responsible for the child's emotional development; rather, the unique individual capacities of the infant are seen as exerting a very direct influence on the parents' behavior. Research opportunities defined by the interactionist approach to development are identified. With infant mortality rates down and most childhood communicable disease conquered, future research and national pgorams may focus on child development and successful early progress.

297. **Room, R. (1981). The case for a problem prevention approach to alcohol, drug and mental problems *Public Health Reports, 96*, 26–33.**

A preventive approach to problems of alcohol, drugs, and mental illness is proposed. It is argued that the efforts of the currently popular mental health promotion movement overemphasize prevention programs for children and rely on vast and vague goals that cannot be met. Recommended is a disaggregative approach, which would identify specific alcohol, drug, and mental problems and consider strategies and agents that can be adopted to bear on them. It would address deep-seated problem areas in social interaction, seek to modify existing conditions that foster aberrant behavior, and identify specific target populations and the contexts for prevention efforts. Such an approach is deemed superior to a disease prevention strategy, which is troubled with constraints of nosology, and the health promotion approach, which focuses on strategies of persuasion and education about behavior that is commonly difficult to change.

298. **Sameroff, A.J. (1977). Concepts of humanity in primary prevention. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 1: The issues* (pp. 42–63). Hanover, NH: University Press of New England.**

The article discusses alternative views of children as persons whose mental and physical makeup are largely influenced by environmental factors or as "things" whose constitutions are largely determined by factors that cannot be influenced. Thus, children whose characteristics are seen as the consequence of an ongoing adaptation to a set of life circumstances will be viewed more as persons and be given a higher prognosis for beneficial change through alteration of any pernicious life circumstances. On the other hand, children will be given a poor prognosis for beneficial change if their problems are viewed as being largely determined by poor genetic, reproductive, or caretaking histories. The article also addresses the debate over what factors contribute to low IQ, poor adjustment, and child abuse in children, and it is concluded that no one factor alone can serve as a complete explanation. Instead, a transactional model that stresses the reciprocal influence of the child and his/her environment is presented. It is argued that only through a clear understanding of the developmental process in children can real progress be made in primary prevention.

299. **Solyom, A.E. (1981). Mental health consultation in infant day care: A new frontier of prevention. *Infant Mental Health Journal, 2,* 188–197.**

The mental health aspects of infant day care are discussed, emphasizing the fact that mental health input into the design, implementation, and ongoing supervision/evaluation of the majority of day care programs is minimal at the present time. The following three criteria are proposed for judging the adequacy of mental health input in a day care program: (1) ongoing mental health consultation to the caregiver staff on a weekly basis and by the same clinician; (2) assignment of primary caregivers to the infants; and (3) periodic naturalistic observations of the infants to be recorded and discussed by the caregivers. It is postulated that consultation to the caregiver staff of infant day care programs represents the opportunity to establish a new frontier of prevention. Therefore, the mental health profession should consider it a goal that every infant day care setting have a mental health clinician as a consultant. The methods, preventive functions, and manpower aspects of such consultation work are discussed.

300. **Weinberg, R.A. (1979). Early childhood education and intervention: Establishing an American tradition. *American Psychologist, 34,* 912–916.**

This article traces the influence of recent social, political, and economic forces on the evolution of American early childhood education. Since the learning experiences of young children affect development in major domains of their behavior, it is no surprise that contemporary early education practices have been shaped by the knowledge base of developmental psychology. Project Head Start, a massive Federal social experiment, is presented as a fertile spawning ground for alternative models of early intervention, psychoeducational remediation, and preschool education. Psychologists are urged to continue their participation in the early education enterprise. The author shares some reflections that might give direction to these efforts. ©APA.

301. **Woods, R.F. (1982). Learning to walk in a brave new world: Prevention and intervention with infants and families. *Journal of Children in Contemporary Society, 14,* 35–42.**

A primary concern of prevention is the infant at risk for a variety of disorders. The area of greatest concern is that of human attachment. Attachment is a process of developing a relationship with a significant other. Signs of the existence and quality of an attachment include use of the significant other for familiarization, gratification of needs, comfort, and affectivity and as a secure base from which to explore. Using the new body of knowledge about human infancy, it is possible to develop prevention programs that follow a five-step process: (1) setting goals and objectives, (2) screening and identifying a population, (3) assessing strengths and needs, (4) selecting appropriate interevention methods, and (5) evaluating. ©APA.

See also: 16, 17, 81, 87, 103, 104, 140, 190, 193, 196, 200, 218, 249, 251, 253, 271, 305, 307, 310, 327, 329, 350, 353, 367, 381, 400, 407, 411, 420, 665, 678, 680, 752, 835, 881, 903, 920.

B. Intervention During Pregnancy

302. **McNeil, T.F., & Kaij, L. (1977). Prenatal, perinatal, and postpartum factors in primary prevention of psychopathology in offspring.** In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 1: The issues* (pp. 92–116). Hanover, NH: University Press of New England.

The topic addressed in this article is the primary prevention of psychopathology in offspring based on factors in the mother during pregnancy, delivery, and the post partum period. Literature tying obstetric complications to increased risks of mental disorders is cited. The Swedish Prenatal and Child Health Care System is given as an example of a primary preventive effort designed to reduce obstretic complications and hence disorders that might result from them. The article discusses in detail how the system works, the lessons that have been learned from this preventive endeavor, and the special considerations that need to be taken into account with pregnant mothers who have histories of nervous mental disorders.

303. **Masterpasqua, F., Shuman, B.J., Gonzalez, R., and O'Shea, L.T. (1980). Integrating early parent-infant psychosocial support into neighborhood clinics: An ecological intervention.** *Infant Mental Health Journal, 1,* 108–115.

This paper describes a program of early psychosocial support for low-income parents and infants that was established at an inner-city family health center. Such a program meets many of the criteria of successful early psychological intervention by beginning during the prenatal period and extending through the first 3 years of life, providing professional and peer support to the parent-infant system, responding to the social as well as psychological needs of low-income parents, and embedding preventive intervention into an accessible neighborhood setting. ©APA.

304. **National Association for Mental Health (1973).** *Primary prevention of mental disorders with emphasis on prenatal and perinatal periods: Action guidelines.* Arlington, VA: Author.

This 25-page publication is concerned with developing action guidelines to promote preventive interventions during the prenatal and perinatal periods of human development. The national goal of the organization is to "insure that mothers and children during the prenatal and perinatal period (up to six months) are provided with medical care, psychological supports and responsive social systems which are available, accessible, and appropriate to the prevention of mental disorders and the maintenance and promotion of their mental health." National objectives and guidelines for developing an action program to foster the organization's goals are listed. Guidelines are focused in three areas. The first involves attempting to improve the chances that infants will be born physically healthy. The second advocates the development of parent skills in coping with the potential life crisis surrounding pregnancy and early parenthood. Finally, changes that can be made in the medical, social welfare, family court, day care, public education, and family counseling services to improve the quality of service provided to prenatal/perinatal populations are given.

305. **Shapiro, L.R. (1982). Prenatal and genetic influences related to the prevention of developmental disabilities and emotional disorders. In E. Aronowitz (Ed.), *Prevention strategies for mental health* (pp. 11-23). New York: Prodist.**

An introduction to human genetics and a review of genetic mechanisms is presented. Different modes of inheritance and the genetics of intelligence are briefly discussed. The author then gives a short account of genetic factors related to prevention and states that "an understanding of the various genetic factors related to developmental disabilities and emotional disorders enables primary prevention by means of genetic counseling and amniocentesis for prenatal diagnosis." There are 70 biochemical/metabolic disorders that can now be detected prenatally through amniocentesis, although testing is done usually only when a recognized risk exists. The author states that little is known at present about the genetic factors related to emotional disorders, since it is difficult to separate genetic from environmental factors related to the etiology of psychopathology. Although the author repeatedly includes "emotional disorders" in his discussion of prevention through prenatal diagnosis, it seems clear that at present only developmental disabilities that are physical, not mental, in nature are possible to prevent using the methods described.

306. **Shuman, B.J., & Masterpasqua, F. (1981). Preventive intervention during the perinatal and infancy periods: Overview and guidelines for evaluation. *Prevention in Human Services, 1*, 41-57.**

Recent changes in perspectives on development in prenatal, neonatal, and infancy periods are reviewed, and exemplary preventive interventions and their evaluation are described. Particular emphasis is placed on expanding criteria for successful interventions to include measures of socioemotional and physical health, as well as the more traditional measures of intellectual development. A theme that emerges is the need for peer and professional support for early parenting. The importance of prepared childbirth and its potential impact on mothers' feelings of being able to cope with the newborn is noted. Scales that can be used to assess the early mother-child relationships are described.

307. **Streissguth, A.P. (1977). Maternal drinking and the outcome of pregnancy: Implications for child mental health.** ***American Journal of Orthopsychiatry, 47,*** **422–431.**

Research during the last 3 years with humans and animals is reviewed to indicate that offspring of alcoholic women who drink heavily during pregnancy are at high risk for the physical and mental deficiencies of fetal alcohol syndrome, and that even social drinking during pregnancy may have detrimental effects on birthweight and behavior of infants. Characteristics of the syndrome, in regard to mental handicaps, malformation, and growth deficiency, are reviewed. Several factors important in making prognostic statements concerning intelligence in the syndrome are reviewed, including: (1) the role of the environment; (2) the role of specialized school settings and infant stimulation; and (3) the possibility that the children can outgrow the deficits. It is concluded that primary prevention and active intervention in counseling and obstetrical clinics are needed to prevent women from drinking prior to conception and to promote abstinence from drinking during pregnancy and the nursing period.

See also: 81, 88, 112, 268, 289, 341, 350, 353, 362, 415, 510, 529, 549, 551, 663, 684.

C. Early Intervention with At-Risk Populations

Attempts to screen for or intervene with infants, children, or adolescents who are more at risk for, or vulnerable to, developing psychopathology is an area of primary prevention that can be hard to differentiate from secondary prevention. Articles have been included in this section if they involve a general discussion of, or intervention with, populations that have not yet manifested mental or behavioral disorders but that have required treatment or could warrant a DSM-III classification label.

This early intervention category has been divided into four sections. The first section contains articles that discuss screening procedures to determine at-risk infants, children, or adolescents. The second section includes articles that discuss or describe interventions with children considered at risk by virtue of the mental or behavioral condition of one or both parents (e.g., the mother is psychotic or both parents are alcoholics). The third and fourth sections include articles that discuss more broadly early intervention with at-risk populations. The third section includes conceptual and opinion articles. The fourth section is made up of program descriptions of early intervention with an at-risk population.

1. Screening to Determine At Risk

308. **American Orthopsychiatric Association (1978). Developmental assessment in EPSDT, *American Journal of Orthopsychiatry, 48*, 7–21.**

This study, initially aimed at preparation of a guide for State and local administrators and service providers for EPSDT developmental assessment and treatment, concludes that EPSDT, as currently constituted, cannot adequately meet the urgent developmental needs of the poor children it is meant to serve. Professional and administrative limitations of the program are outlined, and pilot studies to seek solutions are suggested. (Author abstract) ©American Orthopsychiatric Association.

309. **Asbed, R.A., Schipper, M.T., Varga, L.E., & Marlow, E.S. (1977). Preschool roundup: Costly rodeo or primary prevention? *Health Education, 8*, 17–19.**

Preschool roundups represent efforts by educators to identify children whose problems may interfere with their education. This article reports on a project designed to ascertain how productive and cost effective these procedures were in Montgomery County, Maryland. During the spring, a sample of children in a stratified sample of 24 schools was screened through a variety of procedures. Almost half the children had some problem identified through the screening, and health followup recommendations were made for about 20 percent of those. The following year children from the previous year's roundup were systematically observed by their classroom teachers, resulting in a 57 percent agreement in which children were and were not at high risk on both occasions. The authors concluded that the early screening was a cost effective tool for the identification of high-risk children.

310. **Bower, E.M. (1978). Pathways upstream: Risks and realities of early screening efforts. *American Journal of Orthopsychiatry, 48*, 131–139.**

The need for basic societal institutions to foster growth-enhancing and ego-strengthening experiences is highlighted. The ascendancy of Asklepios--as representative of the remedial, medical model--over Hygeia--symbolizing the preventive, public health approach--is traced from Hellenic mythology to present reality.

The Hygeian merits of current early identification programs are considered, and means for moving them closer to the Hygeian ideal are suggested. (Author abstract) ©American Orthopsychiatric Association.

311. **Bradley, R.H. (1978). Screening the environment.** ***American Journal of Orthopsychiatry, 48,*** 114–130.

Use of environmental as well as developmental measures in screening high-risk children is suggested as a solution to some of the problems of EPSDT and similar programs. Defects of present developmental screening instruments are discussed, and recent efforts to refine environmental measurement techniques are reviewed. The need for further research on the impact of environmental variables is stressed. (Author abstract) ©American Orthopsychiatric Association.

312. **Broussard, E.R., & Hartner, M.S. (1970). Maternal perception of the neonate as related to development.** ***Child Psychiatry and Human Development, 1,*** 16–25.

One hundred and twenty full-term, normal, first-born infants were categorized at 1 month of age into a high-risk or low-risk group for possible development of emotional and developmental deviations. The predictions were based on measurements of the mother's perception of her infant as compared to the average. At age 4 1/2, the children were evaluated by two child psychiatrists who had no knowledge of the children's predictive risk rating. A statistically significant association was evident between prediction and outcome. This paper describes the methodology and discusses the implications of the findings. (Author abstract)

313. **Broussard, E.R. (1976). Neonatal prediction and outcome at 10–11 years.** ***Child Psychiatry and Human Development, 7,*** 85–93.

The paper describes findings from a longitudinal study conducted by the author into the relationship between the mother's perception of her neonate and the child's subsequent emotional adjustment. The mother's perception of her child a day or two after birth and 1 month following birth were correlated with the child's subsequent emotional development. Overall, the association between the early maternal perception of the neonate and the subsequent emotional development of the child has persisted over time and is predictive of the probability of mental disorder at age 10 and 11. The instrument utilized to determine the mother's perception was the Neonatal Perception Inventory developed by the author. It determines whether the mother perceives her infant as better than average or not better than the average infant on six behavioral dimensions. High-risk babies are those who are not perceived as better than the average baby. The implications of this study for preventive intervention are discussed.

314. **Cowen, E.L., Pederson, A., Babigian, H., Izzo, L.D., & Trost, M.A. (1973). Long-term followup of early detected vulnerable children. *Journal of Consulting & Clinical Psychology, 41,* 438–446.**

The authors made an 11- to 13-year followup of the subsequent psychiatric histories of over 1,000 children who did or did not participate in a county-wide preventively oriented school mental health program for first and third graders between 1958 and 1961. Clinical "risk" or "vulnerability" judgments were available for program Ss, and reasonably comprehensive third-grade test data were available for all Ss. Early-detected vulnerable Ss were found to have disproportionately high later appearances in a community-wide psychiatric register. Retrospective analyses of the third-grade test data indicate that peer judgment was by far the most sensitive predictor of later psychiatric difficulty. ©APA.

315. **Hersh, S.P. (1978). Sweden's approach to health screening for preschool children. *American Journal of Orthopsychiatry, 48,* 33–39.**

The findings of a recent study of the approach taken by Sweden to a perceived problem in that nation's health care system are reviewed. The Swedish experience is discussed in terms of its application to the United States, with particular reference to early periodic screening diagnosis and treatment and the newly proposed Child Health Assessment Program. (Author abstract modified)

316. **Johnson, D.F. (1982). Newborn screening and intervention in the context of health care. *Infant Mental Health Journal, 2,* 97–105.**

The author describes a special research project designed to develop a method to assess high-risk families in the newborn period. The Borgess Interaction Assessment Screener, which includes measures of situational factors, intrapartum interactions, and observations, is described, including reference to scoring and interpretation. Screener data on 246 mother-infant pairs show the relationship of risk situations such as history of mental illness and substance abuse, employment and marital status, and social support to assignment in the high-risk group. Note is made of an intervention program that is an important companion of the high-risk screener project. ©APA.

317. **Katoff, L., & Reuter, J. (1980). Review of developmental screening tests for infants. *Journal of Clinical Child Psychology, 9,* 30–34.**

Developmental screening for infants is examined, and a critique of the 21 available measures for use in primary prevention of developmental disabilities and their sequelae is presented. The reliability, validity, and test and scoring procedures of each measure are described. The critique indicates that there is no reliable and valid instrument that is sufficiently economical, includes the necessary developmental areas, is designed exclusively for use with children of developmental ages below 12 months, is appropriate for use with at-risk populations, and includes an appropriate manual. A new instrument, the Kent Infant Development Scale, is described as an alternative to existing measures. (Author abstract modified)

318. **Klein, D.C., & Lindemann, E. (1964). Approaches to pre-school screening. *Journal of School Health, 34,* 365–373.**

This article summarizes the presentations of representatives of six pre-school screening projects. Four general objectives were found to characterize most of the projects: early detection or recognition of children with special needs; basic research into the nature of children's coping behavior with stressful situations (e.g., kindergarten entry); the crisis nature of school entry and preventive intervention at that point; and training of mental health professionals to work in this area. The methods used to assess children were also presented. These were oriented to two time periods: preschool and after entering school. The professional makeup of screening teams and specific techniques utilized seemed to vary between the projects. Finally, screening as a preventive intervention was discussed.

319. **Mager, C.A. (1983). Training school-community behavioral health teams in problem clarification and program planning. *Prevention in Human Services, 2,* 75–96.**

The training of School-Community Behavioral Health Teams in problem clarification and program planning is described, outcome evidence suggesting the utility of the approach is reported, and considerations pertinent to its implementation are discussed. The purpose of a School-Community Behavioral Health Team is (1) to help a public school district identify potential and actual behavioral problems of children and youth, and (2) to help school professionals in the planning of programs that address the identified areas. A team comprises a cross-section of school and community representatives who collaborate with program developers and implementers from the school district, by means of a specific problem solving approach, with a focus on maintaining or improving the behavioral health of children and youth. (Author abstract) ©The Haworth Press.

320. **Moore, B.D. (1978). Implementing the developmental assessment component of the EPSDT program.** ***American Journal of Orthopsychiatry, 48,*** **22-32.**

This paper discusses the role of developmental assessment within the Early Periodic Screening, Diagnosis, and Treatment program, describes efforts to develop guides for implementing this component of the program, and summarizes the "developmental review" proposed by the American Association of Psychiatric Services for Children. (Author abstract) ©American Orthopsychiatric Association.

321. **Poser, E.G. & Hartman, L.M. (1979). Issues in behavioral prevention: Empirical findings.** ***Advances in Behavioral Research and Therapy, 2,*** **1-25.**

Some conceptual issues hampering progress in primary prevention of social maladjustments are examined. The authors suggest a model whereby vulnerability, operationally defined in terms of test behavioral performance deficits, interacts with environmental "presses," i.e., life events making additional demands upon an individual's adjustment potential. Those with high vulnerability and high press ratings are considered to be at risk for psychological disorders and, as such, constitute a target population for primary prevention. A group of 64 well-functioning high school students was administered screening tests derived from the above model. Twenty-five percent of the total group found to be high in vulnerability were also found to experience greater environmental stress in the sense of deriving less response-contingent positive reinforcement for engaging in commonly occurring pleasant events. Evidence from a psychophysiological test and 2-year followup data on adolescents at high and low risk suggests that these two groups can be reliably distinguished in terms of variables other than those used in the original classification. The outcome of this study lends support to social skills training as one form of preventive behavioral intervention suitable for adolescents at risk for becoming adjustment casualties. (Author abstract)

322. **Reinherz, H., & Griffin, C.L. (1977). Identifying children at risk: A first step to prevention.** ***Health Education, 8,*** **14-16.**

This article discusses the need for the development of screening procedures for identifying children at risk, and describes a program of screening in Quincy, Massachusetts, as an example. A 20-30 minute battery of instruments is described, including the gathering of health information, measures of learning efficiency, vision and hearing tests, and a parent questionnaire designed to tap the child's social and emotional status. Three categories of risk are defined--high risk (in need of immediate attention), moderate risk (children who will be screened again in the near future to assess their status), and a risk category of children who should be monitored by school personnel during the upcoming school year. Variables in the screening battery that significantly correlate with overall risk status are identified.

323. **Rodnick, E.H., & Goldstein, M.J. (1974). A research strategy for studying risk for schizophrenia during adolescence and early adulthood. In E.J. Anthony, & C. Koupernik (Eds.), *The child in his family: Children at psychiatric risk: III* (pp. 507–526). New York: Wiley.**

The article describes a schizophrenic risk-identification research strategy that (a) identified conditions that may contribute to the onset and course of development of schizophrenic behavior, (b) studied a cohort of high-risk adolescents, (c) conducted a prospective study of the high-risk cohort, and (d) completed retrospective studies of adult schizophrenics to cross-validate the predictive significance of those precursors identified in the prospective study. ©APA.

324. **Stringer, L.A. (1978). Mental health work in children's health centers: Learnings from five year's experience. *American Journal of Orthopsychiatry, 48*, 40–55.**

A 5-year-old program describing early periodic screening, diagnosis, and treatment is examined with respect to: (1) its potential for prevention of disabling conditions and (2) the kinds of problems encountered and solutions attempted. Two glaring needs appear---for stronger support systems and for more relevant training in outreach work. (Author abstract) ©American Orthopsychiatric Association.

325. **Sturner, R.A., Funk, S.G., Barton, J., Sparrow, S., & Frothingham, T.E. (1980). Simultaneous screening for child health and development: A study of visual/developmental screening of preschool children. *Pediatrics, 65*, 614–621.**

The feasibility of obtaining clinically useful developmental information during pediatric health examinations was explored. Standard preschool vision screening procedures were modified so that developmental capability and behavioral responses could be recorded and quantified. A sample of 440 children aged 4 and 5 were screened by lay people in an 8-minute procedure. For a subsample of 129 children, scores from a cognitive measure were compared with results of the vision screening. A high level of agreement was found between results of the two measures, indicating that a screening procedure aimed at the early identification of children at risk is feasible.

326. **Ullman, D.G., & Kausch, D.F. (1979). Early identification of developmental strengths and weaknesses in preschool children.** ***Exceptional Children*, *46*, 8-13.**

The ability of the Minnesota Child Development Inventory (MCDI) to identify developmental strengths and weaknesses was investigated with 60 nursery school children and 62 Head Start children. As expected, the MCDI identified more problems in the high-risk Head Start group and, for five of the eight developmental areas, significantly predicted subsequent Head Start teacher evaluations of each child. Modifying the MCDI cutoff score reduced substantially the false negatives. Thus, the MCDI shows promise as a useful developmental screening instrument for lower socioeconomic, preschool age children. Implications for remedial planning are addressed. ©APA.

See also: 6, 291, 292, 336, 345, 347, 365, 369, 370, 371, 373, 381, 382, 383, 385, 390, 394, 435, 627, 680, 749.

2. At Risk Due to Condition of Parents

327. **Anthony, E.J. (1982). The preventive approach to children at high risk for psychopathology and psychosis.** ***Journal of Children in Contemporary Society*, *15*, 67-72.**

The author discusses four crucial issues affecting the possibility of preventive interventions for children at high genetic risk for psychopathology and psychosis: (1) whether the transmission is genetically and/or environmentally determined, (2) whether the goal is the prevention of psychopathology of varying severity in the offspring of psychotics or the prevention of psychosis in the adult, (3) whether the concept and pursuit of prevention itself is undesirable or whether one should strive for the optimal well-being of the individual at risk, and (4) whether intervention should be regarded as a "one-shot" effort or be applied continuously or intermittently through the life cycle of the individual. It is argued that primary prevention should not only be directed at the transmission of psychosis to the next generation of adults but also at the relief of suffering and psychopathology in children, keeping in mind that the two may be causally related and that genetic and environmental factors are constantly interacting. ©APA.

328. **Erlenmeyer-Kimling, L. (1977). Issues pertaining to prevention and intervention of genetic disorders affecting human behavior. In G.W. Albee & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. I: The issues* (pp. 68-91. Hanover, NH: University Press of New England.**

It is argued that there can be no basis for the primary prevention of psychopathology without a clear understanding of the etiology of those disorders that society hopes to prevent. The article summarizes what is known about the genetic risks of various mental disorders. In schizophrenia, it is concluded that children with one schizophrenic parent have from a 7 to 19 percent higher probability of acquiring the disorder than children of nonschizophrenic parents, and that the rate increases to about 39 percent if both parents are overtly schizophrenic. There also appears to be substantial evidence for a genetic predisposition to the affective psychoses and perhaps even a higher risk for offspring of affective disorder parents than schizophrenic parents. The possibilities and problems inherent in early identification and prevention of genetic defects in children through such means as genetic counseling, amniocentesis, and abortion are discussed. Finally it is reiterated that nonspecific global efforts at primary prevention may not prove fruitful and that continued efforts in research to try to unravel the etiology of mental disorders is needed.

329. Goodman, C., & Putter, Z. (1972). Children of mentally ill parents: Whose responsibilty? *American Journal of Orthopsychiatry, 42,* 329-330.

This paper provides an analysis of some of the problems experienced by the children of mentally ill parents. This is accomplished by examining the philosophy and organization of patient care and community services, reviewing the literature on the subject, and scrutinizing beliefs and attitudes about child care. A program for the treatment and education of mentally ill parents that involves participation with their children in a nursery school is described, and recommendations for research, training, and development of services are proposed. Recommendations are based on findings that despite the added risk faced by children of mentally ill parents, there are relatively few services for treatment or intervention. It is concluded that the current state of neglect is a function of several confluent factors: (1) a lack of commitment to the rights of children; (2) a function of the response to crisis rather than the development of preventive approaches to the problems of mental health; (3) the self-imposed limitation of traditional approaches to patient care; and (4) a lack of coordinated effort among agencies and disciplines in the human services arena. (Author abstract modified)

330. **Holman, S.L. (1979). An early intervention program for developmentally at-risk toddlers and their mothers. *Clinical Social Work Journal, 7,* 167-181.**

This study explores a program devised to enhance the normal development of toddlers whose psychological development was jeopardized by their mothers' emotional difficulties. Theory about separation-individuation suggests that mothers who are depressed or narcissistically preoccupied will be unable to participate in required ways in their toddlers' development. It was hoped that as the mothers' concerns about separation-individuation were addressed within a time-limited group, the mothers would be able to handle more adequately their toddlers' separation and individuation. A 6-month course of weekly meetings with five mother-toddler dyads brought about significant changes in the developmental progress of the toddlers and enhanced the mothers' participation in the separation-individuation process. (Author abstract)

331. **Kahana, B., & Anthony, E.J., (1972). Combining research and service: A multidisciplinary intervention program with children of psychotic parents. *American Journal of Orthopsychiatry, 42,* 333-334.**

This paper provides a description of a multidisciplinary intervention program with children of psychotic parents. The data were obtained from a pilot project of preventive intervention with high-risk children. A three-pronged preventive intervention plan was developed, focusing on the educational, social, and psychological needs of the high-risk child. A group therapy program was designed for the purpose of developing a more realistic picture of the ill parents, for gaining insight into problems of their parents, and for exploring feelings and conflicts of the child vis-a-vis the ill parent. A special educational remedial program was undertaken with children showing interpersonal and educational problems that were reflected in school performance. Lastly, a big brother social program was provided to children whose families lacked leadership and organization and who showed problems in interpersonal interaction. Results were assessed in terms of multiple criteria specific to the divergent treatment approaches. Progress in the group psychotherapy program was assessed using sociometric indexes, clinical ratings, and replies to an attitude scale. Substantial improvement in school performance and in behavior was observed for five of the nine children participating in the social learning program. The improved group on the average was younger. (Author abstract modified)

332. Kolmac Clinic (1981). Untitled. In S. Matlins (Ed.), *Services for children of alcoholics* (pp. 177–185). (DHHS Pub. No. (ADM) 81-1007). Washington, DC: U.S. Goverment Printing Office.

A primary prevention service for young children of alcoholic parents that was implemented at Kolmac Clinic, a private psychiatric and alcoholism day hospital and outpatient facility in Silver Spring, Maryland, is described. The clinic provides a 2-hour weekly program of alcohol education based on the model of activity groups of children 6 to 14 years old. A contract is established with the parents that the child will attend regularly for a minimum of 4 weeks. A structured program is provided to help the children release affect and to undergo a corrective emotional experience. The techniques of the therapist involve identification, imparting information, interpretation, and reassurance. The task of the group is to expand the ego strength of the children and to add to the children's repertoire of coping mechanisms. The following issues are considered: resistance of parents, referrals, funding, cooperation between parent's therapist and child's therapist, reaching children whose alcoholic parent is not a Kolmac patient, and primary prevention programs for children 14 to 18 years old.

333. Lund, M. (1981). Omaha area council on alcoholism, Omaha, Nebraska. In S. Matlins, (Ed.), *Services for children of alcoholics* (pp. 131–137). (DHHS Pub. No. (ADM) 81-1007). Washington, DC.: U.S. Government Printing Office.

A program designed to meet prevention, treatment, and education needs of children of alcoholics, developed by the Omaha Area Council on Alcoholism in cooperation with other community agencies, is described. The first session of the program deals with attitudes children of alcoholics have toward alcoholism and alcohol, and the second session covers the disease concept of alcoholism. Pamphlets and a film indicate the nature of the child's role in the illness, and the film offers some suggestions on how to cope with parental drinking. The third session focuses on the family disease of alcoholism, and the fourth session presents coping skills. In the fifth session, participants list one asset and one liability they have perceived in the other particpants, and then list those liabilities and assets that they perceive in themselves. The sixth session is on communication and the seventh on confrontation. Emphasis is directed to recognizing and acknowledging feelings and on constructive confrontation concerning interactions in the alcoholic family. The last session reviews where each participant started and how much progress has been made.

334. **Mednick, S.A. (1978). Berkson's fallacy and high-risk research. In L. C. Wynne (Ed.), *The nature of schizophrenia* (pp. 442–452). USA: Wiley.**

The fallacy that the use of control groups will guard against the influence of selection bias is explored with respect to studies of persons at high risk for schizophrenia. Drawing from the results of a Copenhagen longitudinal study of children at high risk for schizophrenia and a perinatal study of those at high risk, examples of potential selection bias in such research are explored. Some areas of potential bias which are discussed are: the influence of severity of parent's illness; the effects of developmental changes on comparisons between children and adolescents; and the influence of differences in symptom patterns among schizophrenics. Some ways of overcoming potential selection bias are described. A prospective birth cohort study of a population of around 10,000 is suggested. In lieu of so great an undertaking, ways in which representative high risk samples can be achieved are described.

335. **O'Gorman, P. (1981). Prevention issues involving children of alcoholics. In S. Matlins (Ed.), *Services for children of alcoholics* (pp. 81–100). (DHHS Pub. No. (ADM) 81–1007). Washington, DC: U.S. Government Printing Office.**

Literature concerning primary prevention for children of alcoholics, which includes health, mental health, and alcohol-related problems, is reviewed. It was found that no one profile of the child of the alcoholic and no one prevention strategy will cover the range of potential problems for which the child is at risk. Ideally, comprehensive programs need to be evolved, or programs with specific objectives must adopt specific strategies. Children of alcoholics have been found to be more likely to be admitted to inpatient and outpatient care complaining of ills for which no organic cause was found. Some research has indicated that children from homes with a pattern of excessive alcohol consumption and social deviance tend to develop these same patterns as adults. On a programmatic level, primary prevention seeks to achieve a behavioral or consequential outcome based on information and education. The challenge for prevention approaches that deal with children of alcoholics is to avoid stigmatizing the child and to help the child develop appropriate coping mechanisms.

336. **Oppenheimer, R. (1981). At risk: Children of female psychiatric inpatients. *Child Abuse & Neglect, 5*, 117–122.**

The need is examined for an adult psychiatric inpatient screening program to identify, assess, and treat emotional and physical trauma to the young children of female psychiatric patients. In a previous study, it was found that 28 percent of adult admissions to a large urban psychiatric hospital were parents of dependent children. Of admissions, 19.6 percent were mothers, and 13 percent were mothers of preschool children. This paper considers the service implications of these previous findings. Two case examples are given of preschool children, known to psychiatric services, who died. In each case there was a lack of assessment, prior to discharge, of the mother-child relationship, and lack of communication between health and social services and the primary care team. It is suggested that there should be routine training of psychiatrists, mental health nurses, social workers, and other disciplines in collaborative assessment and treatment of the adult psychiatric patient's role as mother. The lack of this training appears hazardous and detrimental to the needs of the patient. Examples are given of assessment and intervention methods applicable to an adult psychiatric ward setting.

337. **Peterson, M.K. (1982). Providing support for infants in severely disorganized families. *Infant Mental Health Journal, 3,* 117-125.**

The author describes an infant mental health program that provides both clinical and preventive services to severely disorganized families. Such families are characterized by parents who have limited parenting skills due to their own chaotic childhood, patterns of drug or alcohol abuse, perceptions of victimization, a lack of control over their environment, and a negative or absent father. Intervention focuses on establishing a trusting working relationship with the parents, helping the parents share their frustrations and anxieties, and assessing the strengths of each family member. The functions of treatment teams are discussed, with emphasis on reducing stress on the family and managing the case if the infant has to be removed from the family. The role of the infant specialist in court proceedings, the importance of support for the family in its repetitive personal and environmental crises, and the resolution of termination are discussed. ©APA.

338. **Rolf, J.E., Bevins, S., Hasazi, J.E., Crowther, J. & Johnson, J. (1982). Prospective research with vulnerable children and the risky art of preventive intervention. *Prevention in Human Services, 1,* 107-122.**

The Vermont Vulnerable Child Development Project is presented as an example of community-based preventive intervention research employing multiple control groups and prospective epidemiology. Discussion emphasizes both methodological issues and the pragmatics involved in choosing to use community institutions to study preventive interventions for very young multirisk children living with their mentally disturbed parents. Further, a rationale is provided for anticipating and coping with the political, sociological, and personality conflicts that are probably inescapable in this type of mental health research. (Author abstract)

339. **Sturges, J.S. (1977). Talking with children about mental illness in the family.** *Health & Social Work, 2,* 87–109.

The author suggests that talking with a therapist can help children with mentally ill family members develop characteristics associated with invulnerability to mental illness. These discussions may involve listening to the child's experiences and feelings, providing them with some intellectual understanding of the illness, and guiding them in using their own problem-solving abilities. ©APA.

340. **Watt, N. F. (1979). The longitudinal research base for early intervention.** *Journal of Community Psychology, 7,* 158–168.

An empirical research basis for early identification of psychoses and active efforts to prevent them or moderate their severity is discussed. Retrospective evidence is presented for historical continuity of deviance in the lives of many psychotic adults. Two promising avenues of early intervention are examined: one focuses on the children of psychotic parents, who are known to have an elevated risk for psychosis, and the other is directed at emotionally deviant children in public schools. Major obstacles to effective social action toward these aims are considered, the most forbidding involving prospective interventions in the public schools. Recommendations for action by mental health professionals are offered.

341. **Wright, J.M. (1981). Fetal alcohol syndrome: The social work connection.** *Health & Social Work, 6,* 5–10.

The author describes characteristics of the fetal alcohol syndrome (FAS) and emphasizes prevention and techniques for helping the affected infant and family members. Symptoms include growth and mental retardation and unusual physical development. Prevention possibilities include providing information through school programs, holding discussions in women's groups for the social drinker, and offering social/counseling services to the heavy drinker. When the condition does develop, family problems may be severe due to irritability and sleep disturbance in the child, guilt and denial on the part of the mother, and anger and blame expressed by family members. The situation is further complicated by ethical and legal considerations affecting the physician's role in treating pregnant alcoholics. Alcohol treatment counselors, family planning personnel, and developmental disabilities specialists play a part in support and treatment at various stages of intervention.

See also: 591, 680.

3. General Articles Involving Early Intervention With At-Risk Populations

342. **Anthony, E.J. (1977). Prevention measures for children and adolescents at high risk for psychosis.** In G.W. Albee, & J.M. Joffe (Eds.), ***Primary prevention of psychopathology, Vol. 1: The issues*** **(pp. 164–174). Hanover, NH: University Press of New England.**

After reviewing the literature on children at high risk for psychosis, the author drew two tentative conclusions: (1) environmental aspects of psychosis play a more significant role in causing maladjustment in high-risk subjects during childhood when compared to non-high-risk children; and (2) genetic aspects of psychosis tend to exert their influence later in the life cycle. Six areas emerged as having specific importance for developing and assessing a prevention program for children at high risk for psychosis: risks, vulnerability, competence, maladjustment, prediction, and outcome. Techniques for change, in order of effectiveness, include: classical intervention, corrective intervention, compensatory intervention, and cathartic intervention.

343. Cantwell, D.P. (1974). **Early intervention with hyperactive children.** ***Journal of Operational Psychiatry, 6,*** **56–67.**

This article discusses the hyperactive child syndrome as a relatively common behavior disorder more common in boys and characterized by a symptom pattern of hyperactivity, impulsivity, distractibility, and excitability. Since research indicates that these children are likely to develop serious psychiatric and social problems in adolescence and later life, early identification of the hyperactive child is critical. Four (nonmutually exclusive) areas of intervention are described: (a) The use of stimulant medication may be somewhat effective for subgroups of hyperactive children who have neurophysiological abnormalities; however, 25-33 percent of hyperactive children do not respond to this treatment. (b) Specific training is useful in assisting children to overcome impulsivity and maladaptive responses, thereby decreasing the risk of psychopathology in later life. (c) Successful management of the hyperactive child requires the involvement of the entire family through parent education and the implementation of behavioral programs in the home. (d) Intervention with various types of programs in the classroom is a means of modifying the hyperactive child's problem behavior. The need for long-term studies of the effectiveness of intervention in each of these modalities is stressed. ©APA.

344. **Crissey, M.S. (1977). Prevention in retrospect: Adoption followup. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 1: The issues* (pp. 187–202. Hanover, NH: University Press of New England.**

The use of adoption as an example of a situation where a researcher can follow up on the effects of a marked alteration in life circumstances over a range of 40 years is discussed. Using adoptees who were separated from their natural parents at birth, four groups of children were formed. The first two groups were placed in adoptive homes before 6 months of age, the third group was placed in adoptive homes after experiencing a controlled environment during infancy and preschool, and the fourth group remained in an orphanage. The first two groups showed favorable results of adoption for children, particularly those from disadvantaged family backgrounds who were placed in homes of average or better opportunities. The third group's specific program experience enabled later adoption to take place, and the fourth group had life experiences that accentuated the chances for retardation and adjustment difficulties. The author interprets these results as evidence that children from families with a prevalence of low intelligence, poor school achievement, and social/economic inadequacies can have these deficits ameliorated through drastic changes in life cirumstances in the formative years.

345. **Escalona, S.K. (1974). Intervention programs for children at psychiatric risk: The contribution of child psychiatry and development theory. In E.J. Anthony, & C.J. Koupernik (Eds.), *The child in his family: Children at psychiatric risk: III* (pp. 33–46). New York: Wiley.**

Problems involved in identifying high-risk populations and in developing intervention programs for children assessed at high risk are discussed. The only high-risk population that is defined by actuarial criteria refers to children reared in severe and chronic poverty. Psychiatric risk cannot at present be defined in terms of other specific environmental or biological variables except for extreme instances. However, manifest developmental deviation and/or malfunctioning in itself constitutes a risk factor. The need to understand the interaction between environment and intrinsic, constitutional, and maturational factors in determining developmental outcome is stressed. Programs leading to the identification of developmental disorders as soon as they appear, accompanied by specialized services to meet the needs of these children, constitute an approach that makes best use of the skills of psychiatrists, psychologists, and childhood specialists. Such programs draw on the theory of personality development based on a dynamic and structural interaction model.

346. Field, T.M. (1982). Infants born at risk: Early compensatory experiences. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol 6: Facilitating infant and early childhood development* (pp. 309–342). Hanover, NH: University Press of New England.

In this chapter, a number of studies are presented in brief that demonstrate compensating influences that moderate the effects of such risk factors as respiratory distress syndrome (RDS), low birthweight of the infant, and low SES of the mother. These compensatory influences include medical technology and new neonatal care practices, simple interventions such as providing a pacifier to infants being tube fed, showing the mother the skills of her newborn on the Brazelton, or instituting a home-visit program with teenage mothers.

347. Fish, B. (1976). An approach to prevention in infants at risk for schizophrenia: Developmental deviations from birth to ten years. *Journal of the American Academy of Child Psychiatry, 15*, 62–82.

The author summarizes clinical impressions of developmental deviations in children from birth to 10 years. The research was based on two longitudinal studies that began in 1952 and 1959 on infants at risk for schizophrenia. Behavioral characteristics of the Ss included irregular retardation of motor development, disturbances of body image, poor postural control, secondary sensory deprivation, delayed eye-hand integration, disordered perception and body image, infantile apathy and anhedonia, oversensitivity, symbiosis, excitability, negativism, and aggression. It is concluded that in these studies of high-risk infants, frequent and careful monitoring of developmental deviations provided an important indicator of the preschizophrenic and vulnerable infants most in need of prevention measures and early treatment. It is suggested that prevention based on understanding of the particular child's developmental profile can interrupt destructive interactions between parent and child and may mitigate the psychological sequelae of developmental disorganization. ©APA.

348. **Fish, B. (1982). Attempts at intervention with high-risk children, from infancy on. In M. J. Goldstein, (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 226-241). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.**

This article is a report of several detailed case histories of schizophrenic or schizotypal subjects at risk for schizophrenia, studied from birth to age 20 and 27 in a longitudinal research study conducted by the author. The author gives a discussion of the methods of intervention used with the subjects and evaluates their success. The main conclusion drawn is that in order to truly be primary prevention, specific intervention techniques must be implemented early in life (infancy through age 2). Specifically, the author points to a depression of arousal in the gross motor, proprioceptive, and vestibular responses during an abnormally quiet state from birth to age 1 (noted in subjects), which may be related to the blunted affect (also noted) later in life. Based on observed transient delays in skeletal growth during stages of the subjects' development, the author also suggests the possibility of investigation and treatment with the techniques now available for such disorders.

349. **Garmezy, N. (1975). Intervention with children at risk for behavior pathology. *Clinical Psychologist, 28*, 12-14.**

The author discusses risk research; i.e., the study of individuals who are not yet disordered but may be in special danger of becoming disordered because of factors in their lives or personality that are important components of major models of psychopathology. Studies of children at risk for schizophrenia and related disorders are mentioned, especially efforts at intervention to prevent development of disorders in vulnerable children. The factor of competence has been correlated with recovery from disorder and may also be related to risk potential. Three efforts at advanced intervention by developing the competencies of children at risk are described in detail: (a) to instill social competence in preschoolers, (b) to develop cognitive competence in children having a psychotic parent, and (c) to strengthen the role-taking skills of delinquents. The models of etiology underlying selection of these training groups are discussed. It is pointed out that even without intervention, children vary widely in competence and most children of schizophrenics manage to lead productive lives. ©APA.

350. **Harel, S. (Ed.). (1980). *The At Risk Infant*. Amsterdam: Excerpta Medica.**

This publication contains papers selected from those presented at the International Workshop on the "At-Risk" Infant in Tel-Aviv, July 1979. The workshop was concerned with children at risk for later sensory, motor, mental, and social handicaps and aimed to discuss a "practical, interdisciplinary approach to the prevention, discovery, assessment, and management of disabilities." Selected papers are briefly reported and were taken from one of the four main workshop topics, Prospective Parents, Pregnancy and Perinatal Period, Infant and Early Childhood, and Standards for Socio-Ecological Community Health Care Facilities. Among them are papers on the subjects of adolescent pregnancy, child maltreatment, parental training, research design for assessment of mother-infant interaction, community management of the young handicapped child, developmental screening programs, and child maltreatment during pregnancy.

351. **Henggeler, S.W., & Tavormina, J.B. (1978). The children of Mexican-American migrant workers. A population at risk?** ***Journal of Abnormal Child Psychology, 6*****, 97-106.**

The present study assessed intellectual, academic, and emotional strengths and weaknesses of a group of Mexican-American children of migrant farm workers. To test the vulnerability hypothesis, the test profiles of these children were contrasted with those of two groups of black children with similar demographic makeup. The children of one group (clinical black) had been referred previously for a psychological consultation while the children of the other (nonreferred black) had not. Across dependent measures, between-group contrasts tended to describe the scores of the migrant children as similar to those of the clinical black children and significantly below those of the nonreferred black children. The findings suggested specific intellectual, academic, and emotional vulnerabilities of the migrant children and demonstrated the need to develop ameliorative programs for these children. (Author abstract)

352. **Jacobs, J. (1981). The child at risk.** ***Canadian Medical Association Journal, 124*****, 1449-1450.**

A summary is presented of the recommendations of the Standing Senate Committee on Health, Welfare and Science, with a focus on influences during development that place a child at risk for later aggresssive, antisocial, or violent criminal behavior. Recommendations refer to services and activities related to intervention and prevention in the areas of education, law, social and medical services, and research. Limitations of these recommendations are noted, and it is suggested that the recommendations be viewed as a springboard for further advances rather than final objectives.

353. **Joffe, J.M. (1982). Approaches to prevention of adverse developmental consequences of genetic and prenatal factors. In L.A. Bond & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 121–158). Hanover, NH: University Press of New England.**

This chapter summarizes research in the areas of genetic, chromosomal, maternal, constitution, and prenatal and perinatal environmental influences on intrauterine and postnatal development. This gives an overview of risk factors at various stages in embroyomic and fetal development. Those genetic and chromosomal factors and environmental events that are associated with deviant development are then considered in light of possible preventive measures. Prevention is broken down into categories of approaches for high-risk populations where targeted infants and mothers are worked with and interventions designed to promote development at very early stages in the causal sequence.

354. **Keith, S.J. (1982). Broadening our concepts of high-risk research. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 305–310). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.**

This paper critically evaluates high-risk research and offers suggestions for conceptualization and future research in this area. High-risk research over the last 20 years is seen as having broader applicability than the prevention of schizophrenia. Schizophrenia is one end-state disorder out of many psychological problems that high-risk individuals may develop. The author argues the merits of a social competence approach to analyzing the problems of schizophrenics. Schizophrenics very often do not need rehabilitation in psychosocial-vocational abilities, they need to be taught these abilities in the first place. This type of approach has implications for designing preventive interventions. The author offers a conceptualization of the different types of high risk preventive intervention: (1) broad selection criteria for what constitutes high risk and a broad intervention; (2) broad selection criteria and narrow intervention; (3) narrow selection criteria and broad intervention; and (4) narrow selection criteria and a narrow intervention. The author states that each of these four strategies has its own advantages and disadvantages. The intrusive nature of primary preventive research is mentioned, and the importance of designing an appropriate intervention for appropriate individuals is stressed.

355. **Kornberg, M.S., & Caplan, G. (1980). Risk factors and preventive intervention in child psychopathology: A review. *Journal of Prevention, 1*, 71–133.**

This paper reviews a total of 650 recent papers on biopsychosocial risk factors and primary prevention of childhood psychological disorders. Recent conceptual models of primary prevention based on combatting risk factors and promoting the competences that might be eroded by these factors are summarized. A number of intervention programs are then described and discussed, focusing on: (1) maternal factors, poverty, infant stimulation, mother-child interaction, and day care and preschool competence promotion in children with and without specific education of parents; (2) methods and techniques of preventive intervention including crisis intervention, development of support systems, and consultation to caregivers; and (3) specific intervention programs for family disruption, hospitalization and illness, transitional periods, and school failure. (Author abstract) ©Human Sciences Press.

356. **Lambo, T.A. (1974). The vulnerable African child. In E.J. Anthony, & C. Koupernik (Eds.), *The child in his family: Children at psychiatric risk: III* (pp. 259–278). New York: Wiley.**

The author describes traditional early childrearing practices among Africans in Nigeria. The sustained physical contact between infant and caregiver, the exposure to many "parents" in the extended family, and other patterns of childrearing are linked to enhanced psychomotor and linguistic development, greater sociability, and the infrequence of mental disturbance. The patterns of childrearing in an urban African community are contrasted with those in a traditional rural area and highlight some of the consequences of changes in parenting received by these children. This way of rearing children is viewed as having an inbuilt preventive focus.

357. **Meier, J.H., Segner, L.L., & Grueter, B.B. (1970). An education system for high-risk infants: A preventive approach to developmental learning disabilities. In J. Hellmuth (Ed.), *Disadvantaged child, Vol. 3: Compensatory education* (pp. 405–444). New York: Brunner/Mazel.**

Research, particularly during the past decade, has led to the identification of two primary groups of infants/children who are at high risk for physical, intellectual, and/or emotional dysfunction: (1) low socioeconomic status and (2) the probable neurologically injured (e.g., lower birth weight or premature infant). A large amount of literature was also accumulated which indicates that, to a significant degree, the risk (i.e., later deficiencies) can be neutralized/negated by early stimulative interventions for many such children. This literature is thoroughly reviewed as support for the author's beliefs that early infant education programs are useful as well as necessary in attempts at primary prevention of later disorders in the "high-risk" child. A suggested early infant educational model based on the developmental theories of Piaget is described and explained.

358. **Neal, J.M. (1982). Information processing and vulnerability: High-risk research. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 78–89). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.**

It is argued that high-risk research must go beyond a focus of comparing children of schizophrenics with children of normal parents and include contrast groups such as children of parents with other psychotic disorders. It is suggested that if information-processing tasks are to pay off as markers of vulnerability, the tasks used will need to be able to assess process, not just global performance deficits. Mechanisms such as environmental influences that may produce poor performance are noted. Suggestions for future research include an expansion to other domains of research, such as the assessment of precursors of delusions and hallucinations.

359. **Nuechterlein, K.H., Phipps-Yonas, S., Driscoll, R.M., & Garmezy, N. (1982). The role of different components of attention in children vulnerable to schizophrenia. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 54–77). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.**

This paper seeks to integrate three recent studies assessing the relationship between various components of attentional functioning in children and vulnerability to schizophrenia. Comparisons are made between five groups, including children of schizophrenic mothers, children of nonpsychotic disordered mothers, hyperactive children, a matched classroom comparison group, and a stratified, normal comparison group. Trends suggest that intensity of attention, overall processing capacity, and nonspecific processing resources might predict global information-processing deficits in children born to schizophrenic mothers. Implications of research on vulnerability indices for preventive intervention are discussed.

360. Orme, J.G., & Stuart, P. (1981). The habit clinics: Behavioral social work and prevention in the 1920's. *Social Service Review, 55,* 242–256.

The early development during the 1920s of a group of social agencies, the Massachusetts Habit Clinics, in which social workers utilized behavioral treatment methods to alleviate behavioral problems of preschool children, is described. Habit Clinic social workers were intimately and vigorously involved in both secondary and primary efforts toward the prevention of childhood behavioral problems. The clinics were initially developed to concentrate on changing habits such as enuresis, refusal to eat, persistent temper displays, and extreme cases of shyness and jealousy. The consequences most often used to change the children's behavior were positive, not aversive. Consequences were individualized to be effective. When psychoanalytic concepts became important in social work thinking, the simple behavioral and preventive notions of the clinics seemed inadequate and old fashioned. Today the Habit Clinics seem modern in their use of a behavioral technology and a preventive focus. (Author abstract modified)

361. Plaut, T. (1982). Reactions to pilot intervention programs from a Federal perspective. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 298–304). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.

The author comments on papers and ideas presented in a conference on the prevention of schizophrenia and shares some of his own views. The author states that from the perspective of NIMH, in order for preventive interventions to be funded, they will have to demonstrate that the intervention is safe and has some potential to be effective. The importance and difficulty of evaluating preventive intervention results is discussed. The author suggests that as a first step over the next 5 to 10 years researchers should try to demonstrate that a range of interventions produce good outcomes that are replicable, and then begin to determine what aspects of the interventions are producing the beneficial effects. The author then discusses present and future funding levels and sources of funding for preventive research supported by NIMH. NIMH's desire to attract high-quality researchers into prevention work and to encourage interaction and cooperation between various mental health disciplines is stated.

362. Robins, L.N. (1978). Evaluation of preventive and therapeutic measures in child mental health. *International Journal of Mental Health, 7,* 129–147.

This paper reviews evidence for the effectiveness of two general areas of primary prevention work designed "to reduce the number of children who at birth are at high risk of mental disorder or retardation, and . . . to reduce the probability that children already born will develop mental disorder." With respect to the first area, three general approaches are discussed--discouraging conception by high-risk parents, preventing damage in utero, and the use of abortion when known exposure to damaging illness or proven mental retardation exists. In the second area, a variety of interventions, physical and psychosocial, are discussed including the use of tranquilizers and behavior modification techniques. Examinations of manpower problems and research gaps in the area of the evaluation of prevention and treatment programs conclude the paper.

363. **Rodnick, E.H., Goldstein, M.J., Doane, J.A., & Lewis, J.M. (1982). Association between parent-child transactions and risk for schizophrenia: Implications for early intervention. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 156-172). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.**

Presented are the results of the UCLA Family Project, which examined the relationship between parent-child interaction and subsequent development of schizophrenia in teenagers referred for behavioral problems. Factors such as intrafamilial environment, parental communication deviance, and affective attitudes are related to schizophrenic outcomes. Implications of findings for early intervention programs are discussed.

364. **Rolf, J.E. (1976). Peer status and the directionality of symptomatic behavior: Prime social/competence predictors of outcome for vulnerable children, *American Journal of Orthopsychiatry, 46*, 74-87.**

Social competence data from four target groups of vulnerable children---children of schizophrenic mothers; children of neurotic mothers; clinic children with externalizing symptomology; clinic children with internalizing symptomology--and from a large control group of their public school classmates strongly suggest that peer-rated social incompetence and presence of externalizing behavior disorders are the best predictors of which vulnerable children run the greatest risk of poor adult outcome. (Author abstract) ©American Orthopsychiatric Association.

365. **Tjossem, T.D. (1976). *Intervention strategies for high-risk infants and young children*. Baltimore, MD: University Park.**

The author discusses the planning and establishment of intervention programs that optimize the development of biologically vulnerable infants and young children at risk for aberrant development, emphasizing new ideas in research, service, and training. The reviews and analyses concentrate on the cognitive and language aspects of development, and the research section includes chapters on process research, caregiver-infant interactions, behavioral research, and the infant's auditory environment. Two demonstration projects are detailed, and casefinding, screening, and diagnosis are discussed. ©APA.

366. **Vance, E.T. (1977). A typology of risks and the disabilities of low status. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol 1: The issues* (pp. 207–237). Hanover, NH: University Press of New England.**

A typology of risk is presented that assumes the possibility of differentiating among pathologies. The author holds the view that the greater the number of relevant interactions between a person whose problems are intimately and complexly derived from their relationship to their society, the smaller the groupings for which single treatment will be appropriate. The model discusses: Type I--problems with genetic or constitutional loading that biases development; Type II--problems that are eventually manifested because a child is associated with psychosocially pathogenic influences; Type III--social problems that result from a network of organismic, psychological, and social influences, both current and historical. The latter is viewed as the group with the most difficulties for primary prevention. Social desirability in low status individuals is discussed, addressing the question of why sexism and racism work, and what their influence on ecological risk is. Issues for primary prevention are universal human development; social competence as a developmental goal, individual differences, the structure of social institutions, age by institutional interactions, and person by institutional interactions.

367. **World Health Organization (1977). *Primary prevention of schizophrenia in high-risk groups: Report on a working group*. Copenhagen: Author.**

In June 1975, the World Health Organization, in collaboration with the National Institute of Mental Health, organized an international meeting for the purposes of (a) assessing the current status of resarch in the early detection and prevention of mental disorders in groups thought to be at increased risk of developing schizophrenia; (b) bringing together current and prospective investigators and an international group of experts who would help them to consider the methods of work and ethical and legal problems involved; (c) considering the possible public health implications of research directed towards the early detection and prevention of mental disorders; and (d) developing guildelines for future research in the area of primary prevention of schizophrenia in high-risk groups. Participants in the meeting were asked to prepare working papers. This report consists of condensed versions of those working papers, which were central to the discussions generated at the meeting, along with summaries of the ensuing discussions. The topics are: (1) reviews of current knowledge of early detection and characteristics of high risk subjects; (2) methods of primary prevention in high risk groups; (3) ethical and legal considerations; and (4) public health implications of early detection and prevention.

See also: 20, 43, 64, 67, 87, 88, 97, 101, 112, 121, 125, 128, 183, 222, 239, 266, 268, 279, 280, 285, 301, 303, 307, 328, 423, 435, 489, 532, 540, 542, 567, 568, 569, 660, 662, 680, 735, 880, 900, 934.

4. Descriptions of Early Intervention Programs With At-Risk Populations

368. **Arajarvi, T., Huttunen, M.O., & Talvinko, S. (1977). Family counselling in the prevention of children's psychiatric disorders: A preliminary report. *Psychiatria Fennica*, 89-95.**

The author describes a 5-year program to follow up 170 children born in Helsinki between July 1, 1975, and June 30, 1976, randomly selected from eight districts representing various social conditions. The families were visited by a psychiatric nurse three to six times during the child's first 6 months of life. Records include self-rating questionnaires for the parents, records of the obstetrical hospitals and baby clinics, and evaluation of parents' childrearing practices and general attitudes toward their child. A rating scale was used to assess the risk of the child's developing a psychiatric disorder. At 6 months the children were divided into four "risk status" categories, and the families were assigned to the counseling or the control group. The first group will receive family counseling for 5 years, aimed at preventing psychiatric disorders in the child. Parents will be given advice on childrearing and will be encouraged to moderate overly strict practices. ©APA.

369. Broussard, E.R. Primary prevention program for newborn infants at high risk for emotional disorder. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 63-68) (DHEW Pub. No. (ADM) 77-447). Washington, DC: U.S. Goverment Printing Office.

A primary prevention program for newborn infants at high risk for emotional disorders is summarized. On the basis of a longitudinal study of 318 normal neonates and their mothers, which indicated that the mother's perception of her neonate was associated with the infant's subseqential emotional development, a primary prevention program utilizing mother/infant group meetings and home visitation was offered to 29 mothers of first-born infants judged to be at high risk for emotional disorders. Preliminary data on infants at 1 year old indicated more optimal scores on Attachment, Separation Indicators, Aggression, and Contact with Nonhuman Environment measures for low-risk infants than for the high-risk infants. High-risk infants receiving intervention were found to have more optimal scores than high-risk/intervention-refused infants, with the comparison group (high-risk/no intervention offered) having the most deviant scores.

370. **Broussard, E.R., & Cornes, C. (1981). Early identification of mother-infant systems in distress: What can we do? *Journal of Preventive Psychiatry, 1*, 119-132.**

Selected findings of longitudinal studies of normal, healthy, full-term, first-born infants are reported in a paper presented to the 1979 Symposium on Infant Psychiatry. Background information on the studies is presented, including development and validation of the Neonatal Perception Inventories. Findings of a 1963 study suggest the importance of maternal perceptions of the neonate as a precursor of human adapation, and provided a basis for an intervention/prevention program for a sample of high-risk newborns in distressed mother-infant systems. Experimental mothers and their infants participated in a 3-year group therapy program emphasizing child development and parenting and designed to foster optimal bonding and psychosocial development of infants. Although there were varying degrees of successful outcome within the intervention and control groups, evaluations of children at 2.5 years indicate that the high-risk children whose mothers had participated in the intervention were functioning more optimally than controls.

371. **Broussard, E.R. (1982). Primary prevention in psychosocial disorders: Assessment of outcome. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 180-196). Hanover, NH: University Press of New England.**

This paper reviews selected aspects of the longitudinal studies of the Pittsburgh First Borns, an epidemiological study of healthy, full-term infants born without physical defect and who have not traditionally been considered at high risk for psychosocial disorder. The focus of these studies has been on the adaptive potential of the infant-mother system and the subsequent development of the infants. The Neonatal Perception Inventories (NPI), a measure of the adaptive potential of the mother-infant unit during the first month of life, is described. High-risk infants were identified as those whose mothers did not rate them as better or equal to the average baby. A primary prevention outreach program was designed to involve half of the high-risk infants, with the other half serving as controls. This program is only briefly reported and a case history of one mother-child dyad is presented.

372. **Dowling, J.J., & Hamada, S.M. (1980). A community mental health clinic's infant-toddler services. *Infant Mental Health Journal, 1,*** 116-122.

A community mental health clinic study of 20 infants at risk is described. The program included 450 visits to toddlers and 200 visits with mothers over a 1-year period. The project is portrayed as a successful approach to providing preventive services to the 0-3 years age group. Recent studies in the development of human competence emphasize the importance of these years in obtaining various social and nonsocial abilities that are crucial to life and/or work satisfaction. ©APA.

373. **George, N.M., Braun, B.A., & Walker, J.M. (1982). A prevention and early intervention mental health program for disadvantaged pre-school children (early childhood, developmental therapy). *American Journal of Occupational Therapy, 36,*** 99-106.

One hundred and fifty-five disadvantaged preschool children, ages 3 to 6, were screened for developmental delays using the Cooperative Preschool Inventory as the primary evaluation tool. Thirty-eight children participated in the experimental group and 20 children were designated the control group. Experimental group children received developmental therapy and their regular classroom experience. In addition, intervention was provided to parents and teachers to affect the child's total environment more positively. The control group received only classroom experience. Sixty-five percent of the control group passed the Cooperative Preschool Inventory pretest compared to 50 percent of the experimental group. On the Cooperative Preschool Inventory post-test, 100 percent of the experimental group passed, compared to only 85 percent of the control group. These results suggest that for disadvantaged children early intervention of developmental therapy and classroom experience help eliminate their developmental delays and provide them with age appropriate development skills. (Author abstract)

374. **Jason, L.A., Clarfield, S., & Cowen, E.L. (1973). Preventive intervention with young disadvantaged children.** ***American Journal of Community Psychology, 1,*** 50–61.

Ten inner-city children, ages 14–31 months, identified through routine well-baby screening in a Neighborhood Health Center as slow in social and verbal development, participated in a program built on a committed human relationship with college student volunteers. The program stressed enrichment, stimulation, verbal modeling, and shaping prosocial behavior. Cognitive growth increased significantly and children were seen as significantly more cooperative, content, happy, friendly, and less distractable after the program. Significant positive change in mothers' attitudes to the program was also found as were relations between in-process ratings of children's program status and intellectual and behavioral change indicators. (Author abstract) ©Plenum Publishing Corp.

375. Jason, L.A., & Kimbrough, C. (1974). **A preventive educational program for young economically disadvantaged children.** ***Journal of Community Psychology, 2,*** 134–139.

A preventive educational program for young, economically disadvantaged children is described and evaluated. Active program components feature a committed human relationship, enrichment, verbal modeling and shaping, and encouragement of prosocial behavior. Program children evidenced significant intellectual growth in comparison to nonprogram controls whose functioning did not change with time. It is concluded that the intervention program significantly improves short-term mental and motor performance. (Author abstract modified)

376. **Jason, L.A., Amicis, L.D., & Carter, B. (1978). Preventive intervention programs for disadvantaged children.** ***Community Mental Health Journal, 14,*** 272–278.

This paper describes a 6-year effort aimed at developing educational interventions for a group of economically disadvantaged children. The program provided an opportunity for psychologists and student paraprofessionals to join with personnel at urban health care facilities in responding to a serious identified community problem—disadvantaged youngsters, ages 1 and 2, who are vulnerable to later school and life difficulties. The intervention succeeded in enhancing academic skills among six groups of disadvantaged toddlers. As ongoing research results indicated the need for new program elements, the university personnel piloted innovations and the health centers gradually incorporated effective components into the existing program. (Author abstract) ©Human Sciences Press.

377. **Leib, S.A., Benefield, G., & Guidubali, J. (1980). Effects of early intervention and stimulation on the preterm infant. *Pediatrics, 66,* 80–83.**

To test the hypothesis that early intervention can enhance development of high-risk preterm infants, a prescribed multimodal sensory enrichment program was designed and implemented within a regional neonatal intensive care unit. It was found that 14 treated infants had significantly higher mental and motor functioning developmental status than control infants, as measured by the Bayley Scales of Infant Development, at 6 months past the maternal expected date of confinement. Mean infant weight gain per day and mean total weight gain during hospitalization were not significantly affected. The data suggest that a prescribed intervention program for high-risk preterm infants enhances the quality of development, but that further studies are necessary to determine the long-term value of such programs.

378. **Lilleskov, R.K. (1974). Experiences with early intervention. *Psychosocial process, 3,* 14–27.**

A program of early intervention using a group day care format for children under 3 in a "high risk" population is described. This program was prompted by findings that later intervention programs (after 3 years) showed limited effectiveness, and that there was a high incidence of developmental pathology in children entering day care at age 3. Some of the problems encountered in the program are outlined, as well as how they were approached and the results of interventions. Detailed case illustrations are given, including descriptions of the child's family situation, the child's progress in the program, work with mothers, and specific changes effected in both the child and mother.

379. **Looney, J., Rahe, R., Harding, R., Ward, H., & Liv, W. (1979). Consulting to children in crisis. *Child Psychiatry and Human Development, 10,* 5–14.**

The efforts of a mental health consultation team to meet the needs of a large population of chldren under acute stress are described. On the basis of a study of children and adolescents living in an American camp for Vietnamese refugees, recommendations were made aimed at accentuating the positive factors of the environment while offsetting the negative and potentially deleterious factors. In the area of primary prevention, recommendations called for: provision of clothing, recreational opportunities, establishment of infant care, preschool programs, provision of preventive medical care, encouragement of interaction between refugees and marines, establishment of meaningful work within the camp, utilization of indigenous leaders, provision of facilities for religious practice, and quick placement and followup services for families. Further recommendations for secondary prevention are also presented.

380. **Mayer, J.B., & Meshel, R. (1981). An early intervention program for high-risk children in a health care setting. *Social Work in Health Care, 7,* 35-43.**

A parent education and child stimulation program for developmentally delayed children and children environmentally at risk is described. The program, developed by the social work and nursing staffs of the Dimock Community Health Center in Roxbury, Massachusetts, addresses the effects of developmental delays and environmental deprivation in the 1-day-old to 3-year-old population. The goals of the program are to maximize the referred child's inherent capabilities, to improve parenting skills, and to improve parent-child interaction. Services include assessment, parents' groups, children's groups, and home visits. Although the program has had success in reaching a resistant client population and in enhancing children's developmental skill levels, both costs and dropout rate are high. (Author abstract modified)

381. **Mednick, S.A., & Witkin-Lanoil, G.H. (1977). Intervention with children at high-risk for schizophrenia. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol 1: The issues* (pp. 153-163). Hanover, NH: University Press of New England.**

The article discusses the long-term goals of the high-risk method of studying schizophrenia and its implications for research in primary prevention, especially as they are embodied in a project being attempted in Mauritius. The authors propose that high-risk research offers the promise of providing means of early detection and suggesting ideas for modes of intervention. They posit that the major objective of universal screening is early intervention with identified risk children. Potential dangers of intervention are also discussed.

382. **Mednick, S.A., Schulsinger, F., & Venables, P.H. (1979). Risk research and primary prevention of mental illness. *International Journal of Mental Health, 7,* 150-164.**

A program of research on early detection and intervention techniques for those at high risk of developing schizophrenia is described. A 1962-72 Copenhagen high-risk study suggested that certain autonomic variables might be useful in early detection. These were utilized in a population assessment of a cohort of 1,800 3-year-old, Mauritian children. The group of autonomically defined high-risk children was divided in half. Half the children were placed in specially established nursery schools and half served as controls. These two groups were matched with low-risk control groups. The children's play behavior was assessed after 3 years. The chief effect of the nursery school intervention was to increase the high-risk group's engagement in positive social interactions. This result paralleled the goals of the intervention. Plans are described for future assessment of the 1,800 Mauritian subjects at age 10. The authors suggest that a multidimensional selection device, rather than a solely autonomic one, would improve detection of those at risk of developing schizophrenia.

383. **Mednick, S.A., Venables, P.H., Schulsinger, F., & Cudek, R. (1982). The Mauritius project: An experiment in primary prevention. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 298–296). (DHHS Pub. No. (ADM) 82-111). Washington, DC: U.S. Government Printing Office.**

This short article gives an update on the progress of the Mauritius project, a long-term longitudinal study of children deemed high- versus low-risk for developing schizophrenia. The project began with the assessment of 1,800 3 year-old Mauritius children. Children were screened as high risk versus low risk on the bases of their fast recovering autonomic nervous system response. Autonomically deviant (high risk) and normal (low risk) groups were admitted to nursery schools in 1963. Other community children, matched for relevant variables, served as controls. These children were assessed again just before entering primary school in 1976 and the results are briefly examined. The authors argue the merits of early intervention at the time children enter nursery school. They caution that the practical success of their project in relation to psychopathology will largely depend on the correctness of the assumption that a fast recovering ANS is partially predisposing to mental illness, particularly schizophrenia. Further data collection involving an 11-year followup of these children is in progress.

384. **Phillips, N.K., Gorman, K.H., & Bodenheimer, M. (1981). High-risk infants and mothers in groups. *Social Work, 26,* 157–161.**

A program designed to provide preventive and corrective services to mothers and their infants at risk for developmental, social, or emotional problems is described. The Mother-Child Interaction group serves primarily lower-class black and Hispanic mothers and their at-risk children under 3 years old. A major aim of the group is to provide an environment for growth that is health oriented, rather than problem oriented. Intervention strategies include providing nurturance and support, modeling behavior, teaching behavioral alternatives, helping mothers identify problems, and encouraging mothers and their children to request help. Group participation helped these mothers learn new ways of responding to anger, increased their awareness of developmental stages and their child's individual style, and decreased isolation by providing opportunities for socialization. Children were able to develop social skills in sharing, communicating, and assertion.

385. **Primary prevention for high-risk new-borns.** *Advance, 30,* 16–17.

A plan defined by Virginia's Department of Mental Health and Mental Retardation to ensure a mentally healthy environment during the child's early years is described. The plan aims at identifying high-risk mothers of newborns, and seeks to improve the mother's view of herself. The Pittsburgh First-Born Preventive Intervention model and the Neonatal Perception Inventory, developed by Elsie Broussard, are utilized. The screening process uses the mother's concept of the average baby as an anchor for comparison of her own infant's behavior. Once a high-risk mother is identified, the family is carefully evaluated and a program is designed to meet the specific needs of that family. Interviews, mother-infant groups, and home visits are undertaken to provide supplementary parenting.

386. **Rauh, V.A., Nurcombe, B., Ruoff, P., Jette, A., & Howell, D. (1982). The Vermont Infant Studies Project: The rationale for a mother-infant transaction program. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 259–280). Hanover, NH: University Press of New England.**

After a brief review of infant intervention projects and their rationale in working with premature and low-birthweight infants and their parents, the authors describe the Vermont Infant Studies project. This is both a research and intervention project in which the relationships between antecedent risk factors (i.e., birth weight, gestational age, infant state organization), intermediate factors (i.e., socioeconomic status, social stress, parental confidence, quality of mother-infant interaction), and outcome variables (i.e., infant cognitive-motivational development and temperament, parental adjustment) are investigated. Enhancement of mother-infant interaction is the focus of the Mother-Infant Transaction Program (MITP). The MITP is an individualized, experiential primary prevention program delivered to all mothers of low-birthweight infants by a pediatric nurse during the infant's hospital stay and for four home visits during the 3 months after discharge. An evaluation and followup at 1 year is planned, but the project is too new to have data on its effectiveness.

387. **Resch, R.C., Lilleskov, R.K., Schur, H.M. & Mihalov, T. (1977). Infant day care as a treatment intervention: A followup comparison study.** *Child Psychiatry & Human Development, 7,* 147–155.

The authors evaluated the effects of early day care intervention for young children at risk for psychiatric and or developmental pathology by comparing two groups of children: (a) 10 3-year-olds entering regular day care who had been in an infant day care treatment from ages ranging from 3 to 18 months, and (b) 14 normal matched 3-year-old controls entering regular day care for the first time. All Ss were assessed for general pathology, play, socialization, and separation variables in arrival, play, and mealtime situations, and were naturalistically observed in the day center. No signficant differences between groups were found on any of the variables within situations or across situations, supporting the hypothesis that the treatment intervention supported major positive emotional developments and that the early separations were not detrimental in effect. Significant differences between the two groups on clusters of variables suggest patterns in coping and disturbance style specific to the control group. ©APA.

388. **Rickel, A.U., & Smith, R.L. (1979). Maladapting preschool children: Identification, diagnosis, and remediation.** *American Journal of Community Psychology, 7,* 197–208.

The authors evaluated a preschool intervention program conducted as a part of a university project. The project's aim is (a) to provide early identification of preschool age children experiencing mental health problems and (b) to reverse the diagnosed deficiencies, particularly among high-risk children. The program was evaluated with 132 3- to 4-year-olds within demographically comparable regions in the Detroit school system. Pretest and posttest measures were taken on the AML (Acting-Out, Moody, Learning Disability) Scale and the Caldwell Preschool Inventory. Pretest scores were used to establish comparability of the student populations of the two regions and to identify high-risk Ss. A prescriptive intervention program was established within one region, aimed primarily at reducing adjustment problems among high-risk Ss. The analysis of posttest data revealed more favorable scores among experimental Ss when compared to control Ss. In addition, evidence is provided of specific benefits for high risk Ss in the experimental program. ©APA.

389. **Rickel, A.U., & Lampi, L. (1981). A two-year followup study of a preventive mental health program for preschoolers. *Journal of Abnormal Child Psychology, 9,* 455–464.**

The authors assessed and compared the long-term effects of a preschool intervention program for high-risk children, a placebo control group, and low-risk normal controls. Seventy first-grade children, 28 of whom were controls, were involved in this 2-year followup. The experimental treatment group was superior to that of the placebo control group at followup on the criteria measures of behavioral adjustment and achievement. Results for the low-risk normal control group were significantly different from those for the placebo control groups but generally not significantly different from those for the experimental groups, suggesting that the intervention had boosted the high-risk experimental treatment Ss to the point where their performance was comparable to that of those who had not experienced behavioral or learning difficulties. ©APA.

390. **Rolf, J.E., & Hasazi, J.E. (1977). Identification of preschool children at risk and some guidelines for primary intervention. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 1: The issues* (pp. 121–152). Hanover, NH: University Press of New England.**

The Vermont Child Development Project (VCDP) is described, and an example of applied research investigating the etiology of behavior disorders in early childhood is presented. The authors consider both genetic and environmental factors involved in the etiology, and the early intervention strategies of the program are enumerated. The rationale, epidemiological survey methods, intervention procedures, means of identifying children at varying degrees of risk, and some of the pitfalls encountered are discussed. Children have been selected from several high-risk groups, and the authors are investigating the effects of varying levels of intervention on selected aspects of social, cognitive, and behavioral development.

391. **Rolf, J.E., Fischer, M., & Hasazi, J.E. (1982). Assessing preventive interventions for multi-risk pre-schoolers. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready?* (pp. 259–286). (DHHS Pub. No. (ADM) 82-1111). Washington, DC: U.S. Government Printing Office.**

This article discusses the preventive intervention and research of the Vermont Child Development Project. The project has involved four components: (1) epidemiological surveys; (2) high-risk family studies; (3) preventive intervention studies involving children of disturbed parents, disturbed children, and children with developmental lags; and (4) grade school "follow-along" surveys. The preventive intervention program in this project involved six separate components: day care curriculum, consultation-education, referral service, direct child treatment, parent and family treatment, and advocacy and follow-through. Each of these components is described. Children in the intervention project could receive different components individually or in combination. Selection criteria, assessment methodology, and results of the preventive intervention are discussed. Eighty percent of the children improved by the end of treatment on various measures of intelligence and social behavior. The authors discuss involving disturbed parents in preventive interventions and describe the clinical judgments they used to determine potential responsiveness to treatment for children of disturbed parents.

392. **Schaeffer, M.H., Kliman, G.W., Friedman, M.J., & Pasquariella, B.G. (1981). Children in foster care: A preventive service and research program for a high risk population.** ***Journal of Preventive Psychiatry, 1,*** **47–56.**

A longitudinal description is provided of a preventive research and service response to psychological needs of children upon first placement in foster home care and a facilitating intervention for permanency planning. Foster families often have to contain the disruptive and rejection-provoking behaviors of foster children. Such behaviors are frequently pathogenic sequelae related to the situational crisis of removal from known to unknown objects. This program's research is based on a short-term clinical intervention involving foster children, the biologicial parents, the foster parents, and the county department of social services' caseworkers, clinical evaluators, psychotherapists, and followup workers. There are two experimental groups that differ as to quantity of treatment provided. Predictions, evolving hypotheses resulting from interim findings, and emerging issues are discussed.

393. **Schiff, S.K. & Kellam, S.G. (1967). A community-wide mental health program of prevention and early treatment in first grade.** ***Psychiatric Research Reports, 21,*** **92–101.**

This paper describes an intervention project with first graders in Chicago designed to provide preventive and early intervention services. Basic elements in the general paradigm include (1) specification of a target population, including people suffering from mental illness and those potentially at risk, (2) assessment of need within the target population, (3) assessment of effectiveness, which is systematic, related to a total sub-population, and longitudinal, (4) determination of the relevant program context(s) for the program in the community, and (5) determination of the context-relevant "treater(s)" for carrying out the program. The remainder of the paper discusses how each of these five elements were operationalized in the development of the intervention program. Rationale for selection of first graders and for the choice of school staff as the most relevant context "treater" is provided. In addition, the role of an external mental health consultant to the program is described, and various types of meetings with teachers and parents are outlined to clarify the functioning of the program.

394. **Schulsinger, F., Mednick, S.A., Venables, P.H., Ramon, A.C., & Bell, B. (1975). Early detection and prevention of mental illness: The Mauritius Project. *Neuropsychobiology, 1*, 166–179.**

Between 1972 and 1973, 1,800 3-year-old Mauritian children were studied socially, psychologically, pediatrically, and psychophysiologically. One hundred of these children were selected for experimental preventive intervention during their daily presence in two modern kindergartens. Members of this group were characterized by abnormally fast autonomic recovery or autonomic nonresponding (high-risk group), or normal autonomic responding (low-risk group). A matched group of another 100 children served as a community control. Preliminary results from the screening of the 1,800 children are presented. ©APA.

395. **Zaki, M. (1981). The community approach of a psychoeducational service in Israel. *School Psychology International, 1*, 23–25.**

The author describes a psychoeducational service (PES) in Tirat Carmel, Israel, that has taken a community approach in school psychology. The PES has adopted a preventive model to attack the problems of disadvantaged children in their developmental process, and thus reduce the number of school maladjustment and remedial classes in the community. Preventive measures in preschool years and first grade of primary school and changes of the instruction system in first grade classes are discussed. ©APA.

See also: 95, 276, 280, 350, 363, 662.

D. Early Intervention Involving Project Head Start

396. **Caldwell, B.M. (1974). A decade of early intervention programs: What we have learned. *American Journal of Orthopsychiatry, 44*, 491–496.**

An overview of the field of early intervention with children is presented, specifically the Head Start Program. Four phases are sketched out: (1) Period of Optimism--the initial phase of the Head Start Project; (2) Period of Skepticism--starting in 1967 when data on the project began to be reported, especially the Westinghouse Report; (3) Period of Disillusionment--the post-Westinghouse period. A proposed higher phase is the Consolidation Period; this is when earlier achievements and error are consolidated and used to guide the future. Among the things that have been learned are to not oversimplify the problems or their treatment; people with different kinds and amounts of training can work together with mutual respect and support; by focusing on the evaluation of a program, too narrow a focus can be taken; and continuity from one developmental period to the next is essential, as is followup.

397. **Edelstein, R.I. (1972). Early intervention in the poverty cycle. *Social Casework, 1*, 418–424.**

This article describes the Parent and Child Center Program, a unit of Head Start. A general history of the national program is presented, including both its rationale and the legislative history out of which it sprung. The particular program described in the article is in Whitfield County, Georgia. A portrait of the families who participate in the Center is given, and a variety of approaches to increasing their involvement in Center activities outlined, including the preparation for an Open House and the development of a Policy Advisory Committee, which included significant parent involvement. The actual day-to-day program is outlined, and some implications for the development of new kinds of intervention are noted.

398. **Omwake, E.B. (1979). Assessment of the Head Start preschool education effort. In E. Zigler, & J. Valentine (Eds), *Project Head Start: A legacy of the war on poverty* (pp. 221–228). New York: Free Press.**

A decade of Head Start programming is reviewed in terms of changing foci and demonstrated effectiveness of various components. The author stresses that many of the unsuccessful Head Start programs are not reported and only those that indicate positive gains do become public knowledge, in part to insure future funding. This has led to a biased view of the value of Head Start.

The programs for children have shown little improvement over the last 10 years. However, the education and employment programs have been more successful and are expanding. A more stringent evaluative process is encouraged, with a resultant tougher stance in promoting or firing employees in order to upgrade the quality of programming for the children.

399. **Richmond, J.B., Stipek, D.J., & Zigler, E. (1979). A decade of Head Start. In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 135–152). New York: Free Press.**

Head Start is alive and well in 1975. The author presents the original goals and components of Head Start and evaluates current programs against that backdrop. Programs across the country are individually tailored to meet the needs of the specific population they serve. There is no one Head Start curriculum. This flexibility in programming has resulted in many different services, including programs designed to ease the transition to elementary school, train adults in the community to be child care workers, and meet the needs of parents of children from birth to age 3. Head Start has resulted in gains in cognitive abilities, in physical health, and in the sensitivity of local institutions to the needs of the community.

400. Ross, C.J. (1979). **Early skirmishes with poverty. The historical roots of Head Start.** In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 21–42). New York: Free Press.

Antecedents of Head Start in Anglo-American culture are examined in order to explain some of the implicit assumptions on which the program rests. The roots of Head Start are traced to 16th and 17th century English beliefs that poverty could be prevented through education. Over time, free schools were instituted in England and America, and orphaned children were institutionalized and educated rather than left on the street. During World War II, Federally funded day care was established and in the early 1960s, Aid to Families with Dependent Children was instituted. The author embeds this discussion of the roots of Head Start in the context of changing societal notions about the nature and needs of children.

401. Sale, J.S. (1979). **Implementation of a Head Start preschool education program: Los Angeles, 1965–1967.** In E. Zigler, & J. Valentine (Eds.) *Project Head Start. A legacy of the War on Poverty*. New York: Free Press.

A Head Start Program instituted in Los Angeles in 1965 is described from an insider's perspective. The program consisted of many centers located in poor areas of the city. The guiding philosophy was a traditional nursery school, which emphasizes play as an approach to fostering social, emotional, and intellectual development. The centers pulled together diverse programs that reflected the diversity of the different neighborhoods. The author notes her difficulty in influencing programs, a difficulty she attributes to her formal title and affiliation with the funding and monitoring agency.

402. **Stipek, J., Valentine, J., and Zigler, E. (1979). Project Head Start: A critique of theory and practices. In E. Zigler, E., & J. Valentine (Eds.), *Project Head Start: A legacy of the War on Poverty* (pp. 477–494). New York: The Free Press.**

The authors provide a critical appraisal of the theories guiding Head Start and the problems encountered in their implementation. Drawing on a variety of sources--evaluation studies of Head Start, challenges to the concept of cultural deprivation, and studies of education and poverty over the last 10 years--it is suggested that it is unrealistic and unfair to expect Head Start, or any preschool program, to eliminate poverty. Head Start should actively support the children it serves, make the inclusions of parents an important part of the program, and implement followthrough programs to provide continuity into early school years. The characteristic emphasis on cognitive and intellectual gains of program participants should be tempered and/or expanded to include social, emotional, and physical needs of children. These gains should be addressed in the overall evaluation of Head Start effectiveness.

403. **Stone, N.W., Pendleton, V.M., Vaill, M.B., Slatin, M., Mitcham, C. & Georgette, F. (1982). Primary prevention in mental health: A Head Start demonstration model. *American Journal of Orthopsychiatry, 52*, 360–363.**

A national demonstration project, begun in 1977 to develop approaches to using Head Start's mental health services more effectively, is described. Service objectives are to enhance the developmental support functions of the family and classroom systems and to increase the capabilities of parents, staff, and Head Start children to adapt to and constructively modify those systems and to manage attendant stresses. The goal of primary prevention services for all Head Start children is to increase emotional and social competence, coping skills, and positive self-concept. Two staffing models are used: one involves purchase of services from the local mental health facility; in the other, a paraprofessional mental health worker becomes a Head Start staff member and provides preventive mental health services under the supervision of a professional from the nearby community. Services include staff and parent orientation, staff training, consultation to the administrative teaching staff, educational acitivities for parents, and counseling/crisis intervention services. Program support services (e.g., site visits, conferences, project manuals) also are provided. (Author abstract modified)

404. **Valentine, J. (1979). Program development in Head Start: A multifaceted approach to meeting the needs of families and children. In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 349–365). New York: Free Press.**

Head Start, along with serving millions of preschoolers and their families, has provided a vast range of comprehensive social, health care, and educational services to thousands of poor families and children of all ages. This chapter reviews the broad scope of Head Start activities, gives brief summaries of its many programs, and outlines the goals of the "family" of programs that make up Head Start. These include provision of resources, comprehensive care, continuity of services throughout childhood, and individualization of programs to meet the specific needs of families.

405. **Valentine, J., & Stark, E. (1979). The social context of parent involvement in Head Start. In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 291–313). New York: Free Press.**

The role of parents as decisionmakers in Head Start and the broader issue of the role of self-determination in the long-term success of educational interventions are discussed. Parents have been involved in Head Start programs in two different ways, reflecting different views on the nature of poverty: (1) education of parents, since poverty is an individually based problem or (2) parents as decisionmakers, since poverty is institutionally based. The dearth of research on parents as decisionmakers is stressed. The processes set in action by greater parental involvement in decisionmaking and mobilization of programs is discussed, along with the response of Head Start officials at the national level. Policies and guidelines were drawn up to formalize the role of parents in Head Start. In some cases this resulted in greater participation; in others, it severely limited options open to parents for achieving self-determination.

406. **Wohlford, P. (1973). Opportunities in community psychology: Psychosocial services in Project Head Start. *Professional Psychology, 4*, 277–285.**

The author examines the historical and political aspects of psychological services to Head Start and, based on administrative experience, recommends guidelines for future utilization of psychology. By innovatively defining the role of psychological services as consultative rather than clinical, Head Start assisted in the development of the community psychology concept. Policy issues related to the future role of psychology are summarized as: (a) replacement of the clinical-pathology model with a developmental-community model in which preventive and advocacy functions serve comprehensive developmental needs in the total environmental situation; (b) extension of individualized approaches to children, families, and program staff; (c) continuity of care over time and across consumers; and (d) interdisciplinary cooperation. Recommendations include increasing the level of support for psychological services; maintenance of standards in key programs; policies concerning function, quality, and delivery of psychological services; program content; and accountability. ©APA.

407. **Zigler, E. (1978). The effectiveness of Head Start: Another look. *Educational Psychologist, 13*, 71-77.**

The author presents evidence to refute negative evaluations that have been made against Head Start programs. It is argued that long-term effects of early intervention may depend on the degree to which parents are involved and whether the schools follow the preschool program with further intervention. It is recommended that more money be spent on worker training, that nonpoor children be included, and that inoculation services be added. ©APA.

408. **Zigler, E., & Valentine, J. (Eds.) (1979). *Project Head Start*, New York: Free Press.**

This edited volume provides a progress report of the Head Start program. Head Start is described and placed within a political and historical perspective. The roots of Head Start can be traced to President Johnson's War on Poverty and a basic assumption that poverty could be eliminated through education. Head Start is not a single program, but an umbrella concept that has given rise to a multitude of programs across the country, differing in their emphasis, duration, curriculum, etc. Some of these programs are described. A final question discussed is whether or not the results justify all the effort and expenditure. In this discussion, methodological issues are raised, as are the problems with interpretating and translating results so that they can be used to lobby for continued support of the programs. The authors conclude that this kind of intervention is successful, but only when it is of sufficient duration and includes parents in the programs so that long-term effects are maximized. An extensive bibliography of articles related to Project Head Start is included.

409. **Zigler, E. (1979). Head Start: Not a program but an evolving concept. In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 367–378). New York: Free Press.**

The author critically evaluates research on the effectiveness of Head Start, juxtaposes research reporting conflicting results, and offers new interpretations of the findings and their implications for Head Start, as well as other social institutions. The notion of Head Start as a concept or a center for a variety of programs is proposed as a replacement for the idea of Head Start as a single program designed to raise the IQs of poor children. Furthermore, it is suggested that as programs have evolved from short-term summer experiences to long-term, comprehensive involvement, so has the need for research on Head Start to expand and become more rigorous.

410. **Zigler, E. (1979). Project Head Start: Success or failure? In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 495–507). New York: Free Press.**

The question of Head Start's success or failure as an intervention program with children is discussed in light of its stated goals; improved social competence, health, intellectual ability, social and emotional development, family involvement, and community change. The overemphasis of evaluators on IQ has led to an underassessment of Head Start's impact on preschoolers' development. This overemphasis on IQ is in part due to the availability of standardized measures of intelligence and the dearth of ways to evaluate the achievement of other goals of the program

411. **Zigler, E., & Anderson, K. (1979). An idea whose time has come: The intellectual and political climate for Head Start. In E. Zigler, & J. Valentine (Eds.), *Project Head Start: A legacy of the war on poverty* (pp. 3–19). New York: Free Press.**

In this chapter, the political and social tenor of the times which led to the establishment of Head Start are discussed. An important outgrowth of the coming together of the Johnson administration's "War on Poverty" and social science research and interest in child development, Head Start was designed and instituted as an early intervention program for poor children and their parents, with the belief that education was the solution to the problem of poverty. As research and theory generated in the social science community began to be used as fuel for political debate, misconceptions about the role of environment, the notion of "cultural deprivation," and the long-term effects of short-term early intervention had a significant impact on Head Start programming and on the public's view of the program and the problem of poverty.

See also: 295, 300, 467, 680, 974.

E. Early Intervention Involving Populations Not Defined as At-Risk

412. **Broussard, E.R. (1976). Evaluation of televised anticipatory guidance to primiparae.** *Community Mental Health Journal, 12*, 203–210.

In a controlled evaluation study, programs offering televised anticipatory guidance to primiparae during the immediate post partum period were shown to have a beneficial effect on a mother's perceptions of her infant as measured by the Neonatal Perception Inventory (NPI). Among mothers viewing the programs, a significant increase occurred in the number having a positive perception of their infants at age 1 month. Since the NPI proved a reliable indicator of a child's emotional well-being at 4 1/2, televised guidance is recommended as an effective, economical measure with a potential for reducing the incidence of emotional disorder in children. (Author abstract) ©Human Sciences Press.

413. **Caldwell, B.M., & Smith, L.E. (1970). Day care for the very young—prime opportunity for primary prevention.** *American Journal of Public Health, 60*, 690–697.

This paper describes a day care program and how it might be viewed, and enacted, as an opportunity for primary prevention. The intent of the day care program was to create an environment of educational enrichment for young children. The program was distinctive in its opposition at that time to the idea that children of this age should be cared for in the home. The program is briefly described, and the nature of the participating families outlined. The paper discusses the implications of research on the impact of the program for community planning. Both cognitive enrichment and emotional change goals are described, and the implications of these findings for those involved in early enrichment programs are discussed.

414. **Cary, A.C., & Reveal, M.T. (1967). Prevention and detection of emotional disturbances in preschool children.** *American Journal of Orthopsychiatry, 37*, 719–724.

The Grand Rapids Child Guidance Clinic is discussed. This clinic has provided a "mental health checkup" of mothers and preschool children for the last 9 years. The four purposes of the program are: (1) to provide experiences that will promote the child's healthy ego development; (2) to give mothers understanding of their child's emotional growth; (3) to allay maternal anxiety; and (4) to bring to notice children whose adjustment indicates a need for some kind of therapeutic intervention. The program is offered to the "well child." Mother and child come in one morning per week for 10 weeks. The program consists of a mothers' group and a nursery school program. There are also individual conferences with the mothers. Approximately 25-30 percent of the children are judged to need further intervention. Many mothers have kept up sporadic contact with the center social worker for a period of years regarding care and training of infants and younger children. The authors believe that the service has broad prophylactic benefits; specifically, it fulfills a function in primary and secondary prevention.

415. **Colman, A.D. (1971). Psychology of a first-baby group.** ***International Journal of Group Psychotherapy, 21*****, 74-83.**

This study is focused on the psychology of a first baby group. Its use as one technique for primary prevention of emotional disturbances in the prenatal period is suggested. A group of primaparas was selected from a prenatal clinic and met from early in the first pregnancy through the beginning months of the mothering experience. After delivery, the infants were included in the meetings. The group was intended as a discussion-learning situation rather than as a preventive mental health procedure. Attendance at the group meetings, reasons for absences, and reactions of group members to the meetings and to each other are discussed. The return of new mothers and babies to the group of still pregnant women, and the addition of new primparous pregnant women to the existing mothers' group produced group cohesion difficulties. The mental health implications of these experiences are discussed. It is believed that the first baby group was an unusually effective technique for educating the personnel involved in prenatal, maternity, and well-baby care about the psychological impact of pregnancy and motherhood.

416. **Dobbin, S.L., & McCormick, A.J. (1980). An update on social work in day care.** ***Child Welfare, 59*****, 97-102.**

The role, functions, and goals of the social service department of the Associated Day Care Services of Boston, Massachusetts, and its developmental program are discussed. The goals of the developmental day care program include increasing observation skills, language skills, physical strength, and coordination; providing many and varied experiences; and developing a positive self-concept. It is designed to both strengthen each child at his/her own pace and to develop group awareness. Participation of parents in decisions concerning the children's program is a primary goal. Within this setting, the social service program offers an integrated preventive service to meet the needs of the children and their families. Daily contact between parents and staff and the constant awareness of the pace of the individual child's development provide ongoing opportunity to evaluate child and family functioning as well as access for early intervention in problem situations.

417. **Rafferty, F.T., Taboroff, L.H., & Myers, G.M. (1958). Introduction of preventive psychiatric concepts into a program of total child care. *American Journal of Orthopsychiatry, 28*, 802-808.**

This is the report of an effort (in September 1955) by the Department of Psychiatry and Pediatrics, University of Utah College of Medicine, to introduce a psychiatric discipline into a county hospital well-baby clinic. The effort was motivated by the desire to prevent mental illness/promote mental health and thereby provide total clinical care for children. Several case descriptions are provided. The authors acknowledge that their program was never fully established, as they failed to realize the enormity of their task at the onset. Thus the implementation of a program became only an exploration into the problem of establishing one. Nevertheless, two main conclusions were drawn from the effort. The first is that it seems possible to favorably influence the development of a child's mental health by teaching childrearing practices to the mother and other family members. The second conclusion is that the medically derived concept of mental illness was not successful as a theoretical base for the program, and that a reconceputalization in sociological terms would be more useful.

418. **Reid, H., Brown, S.L., Hansen, Y., & Sperber, Z. (1973). Preventive interventions for the very young: An infant consultation service interweaves service, training and research. *American Journal of Orthopsychiatry, 43*,** 246-247.

This paper describes an infant consultation service that interweaves service, training, and research in preventive interventions for the very young. Assessment of the personnel in the program, their understanding and empathy for clients, plans of the program, and results of a followup interview with clients are discussed. Years of working with families and children emphasized the need for such services for very young children. Training of paraprofessionals and review of the skills of professionals are discussed.

See also: 268, 287, 296, 467, 514, 515, 516, 534, 594, 604, 1006.

V. Competence Building

Teaching and developing skills and competencies in individuals to make them more resistant to psychopathology is one major type of primary prevention strategy. Research articles in this area differ according to the type of skill that is taught as well as the population learning the skill. Articles have been divided into three primary sections. The first section includes those articles that discuss competence building as a strategy of primary prevention from a conceptual or ideological point of view. The second section includes articles involving different types of competence building efforts with children and adolescents. The third category includes articles discussing competence building with adults.

A. Conceptual and Ideological Papers

419. **Albee, G.W. (1980). A competency model must replace the defect model. In L.A. Bond, & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competency and coping during adulthood* (pp. 75-104). Hanover, NH: University Press of New England.**

Psychology, psychiatry, and related professions are criticized for perpetuating an illness or defect model of mental disturbance, and it is argued that this model has persisted because of professional advantage, professional status, profit, and ethnocentrism rather than scientific fact. A competence model is advocated that depends on an egalitarian political and moral philosophy and that emphasizes the concept of adaptive potential. It is contended that mental health professionals can help enhance adult competence by redirecting their attention to environmental causes of psychopathology and by refraining from blaming the victim. The competency model for primary prevention focuses on how competence, coping skills, self-esteem, and social support systems mediate reactions to stress. Examples in support of the model are cited from research on racism and sexism, insanity, deinstitutionalization of mental patients, the concept of genetic superiority, and pseudoretardation among the disadvantaged.

420. Apolito, A. (1978). Primary prevention: A breakthrough in sight. *American Journal of Psychoanalysis, 38,* 121–127.

The author discusses the adequacy of current knowledge concerning the etiology and pathogenesis of mental illness from the standpoint of primary prevention. It is suggested that it is both essential and feasible to develop a method of prevention applicable to all children based on the medical model of immunization for the prevention of epidemic diseases. Psychological immunization involves educating all children before the age of 4 years to deal with threatening psychological forces such as hostility. It is argued that the proposed immunization program, which is based on principles of group therapy, family therapy, and transactional analysis, should be government sponsored, directed, and financed. ©APA.

421. Blair, G.E. (1968). *An urban education first principle: Community education centers.* Albany, NY: New York State Education Department.

The author proposes that urban community education centers be established to provide supplementary education and services to urban ghetto residents who are beyond school age. Organized within a given neighborhood, the centers would function as human resource programs and might utilize local school facilities. Academic, vocational, cultural, recreational, and health programs would be developed. Counseling services and guidance concerning the use and availability of welfare agencies could be included. Preventively oriented preschool classes might also be provided. Nonghetto community resources for both counseling and volunteer personnel would be utilized.

422. Danish, S.J., & D'Augelli, A.R. Promoting competence and enhancing development through life development intervention. In L.A. Bond, & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competency and coping during adulthood* (pp. 105–129). Hanover, NH: University Press of New England.

The authors offer an alternative to primary prevention of psychopathology that suggests a developmental model of competence and contends that stressful life events can be junctures for enhancing adulthood. The role of the self-help movement, as spurred by natural caregivers in communities, and the dispensing of life skills through the mass media are emphasized. A pyramid model of human service delivery, which capitalizes on mutual self-help to provide life development intervention and enhancement, is advocated. This model is in contrast to the remedial or preventive model and includes four distinct skill packages: (1) basic helping skills, (2) life development skills, (3) life crisis skills, and (4) teaching skills. Professional, social, and organizational barriers that may impede such an approach are discussed.

423. **Garmezy, N. (1974). The study of competence in children at risk for severe psychopathology. In E.J. Anthony, & C. Koupernik (Eds.), *The child in his family: Children at psychiatric risk: III* (pp. 77–98). New York: Wiley.**

The author describes Minnesota studies of competence as illustrations of a four-stage research sequence for exploring the correlation between the behaviors of children presumed to be vulnerable to psychopathology and criterion measures of their competence. ©APA.

424. **Garmezy, N., Masten, A., Nordstrom, L., & Ferrarese, M. (1979). The nature of competence in normal and deviant children. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention in psychopathology, Vol. 3: Social competence in children* (pp. 23–43). Hanover, NH: University Press of New England.**

Old and new perspectives on competence are examined by exploring developmental psychology and psychopathology. Topics discussed include: premorbid competence in schizophrenia, competence and vulnerability to psychopathology, and a survey of the emergence of competence in psychological research from 1927 to 1977. It is suggested that whereas the earlier approach to competence was through assessment of intelligence and the elaborate network of behavioral correlates that characterizes effective versus ineffective cognition, more recent research focuses on social adaptation and the relationship of competence to attachment, socialization, parenting, and the development of prosocial behaviors.

425. **Gazda, G.M., & Brooks, D.K. (1980). A comprehensive approach to developmental interventions. *Journal for Specialists in Group Work, 5,* 120–126.**

The theoretical rationale and applications of the life skills training model are presented. The model offers an approach to developmental interventions that may enhance healthy functioning, exert a preventive thrust through educational programming, and facilitate the remediation of psychopathology. It is also suggested that life skills training is an ideal model for use in elementary and secondary schools.

426. **Gladwin, T. (1967). Social competence and clinical practice. *Journal for the Study of Interpersonal Processes, 30*, 30–38.**

The author presents a partial summary of a conference of mental health professionals and NIMH staff members who met to discuss issues of social competence and the role it plays in mental health. Shortcomings of traditional approaches to mental health are discussed first, including insufficient utilization of potential resources and ineffectual meeting of needs for services. An alternative approach suggested would focus on social competence building. Competence is presented as: (1) an ability to utilize various alternatives in reaching a goal; (2) an understanding of social systems of which one is a member and ability to use their respective resources; and (3) effective reality testing. Various ways to achieve these goals are discussed. They basically involve developing environments in which individuals can function effectively. Possible environments range from small closed treatment settings to society as a whole. Examples of various interventions are presented. The complexities of this approach are discussed and the need for professionals to get training in systems theory is stressed.

427. **Gordon, S., & Scales, P. (1979). Preparing today's youth for tomorrow's family. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 297–320). Hanover, NH: University Press of New England.**

A review of the research on teenage sexuality and pregnancy and on the psychological consequences of the decline of the American family is given. Sex education in the nation's high schools and the teaching of equalitarian parenting skills are presented as potentially effective as well as politically risky methods of reducing the number of single-parent families caught in a pattern of poverty and despair. The authors urge preventionists to focus on preparing today's youth for the new roles essential for tomorrow's family of dual-working, dual-parenting couples.

428. **Guerney, B. (1979). The great potential of an educational skill—training model in problem prevention. *Journal of Clinical Child Psychology, 8*, 84–86.**

The beneficial impact that psychosocial skill training can have on the mental health and welfare of the public is examined. Looking at prevention from the perspective of a psychoeducational skill-training model sharply diminishes the apparent differences between psychologically based treatment and prevention. The psychoeducational model emphasizes the role of motivation and provides a positive perspective. The psychoeducational model suggests that preventionists would benefit from a clear emphasis on the positive aspects of programs that meet current needs, and from reducing the emphasis on discrimination between those termed normal from those termed abnormal. Overall, psychosocial skill training can have a revolutionary, beneficial impact on the mental health field.

429. **Hartup, W.W. (1979). Peer relations and the growth of social competence. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 150–170). Hanover, NH: University Press of New England.**

This chapter reviews the field that examines peer play in shaping human social competence. Social competencies derive from the child's interaction with peers as well as family. Strategies for the promotion of social competence include coaching, peer tutoring, social reinforcement, modeling, and nonprogrammed play. Early intervention is urged.

430. **Konner, M. (1979). Biological bases of social development. In M.W. Kent, & J.E. Rolf, (Eds.), *Primary prevention of psychology, Vol. 3: Social competence in children* (pp. 97–119). Hanover, NH: University Press of New England.**

The author, a cultural anthropologist, theorizes about the manner in which the ontogeny of brain development reflects the evolution of social competence in the human species. He draws on an interest in neuroanatomy, his ethological studies of facial expressions of children, and his extensive fieldwork among the Kung Bushmen (a hunter-gatherer society in Botswana). His thesis is that the emergence of age-specific social competencies serves an adaptive evolutionary function to ensure the survival of the child. These competencies are first caused by brain development and are then shaped by social and cultural consequences.

431. **Kuriloff, P., & Rinder, M. (1975). How psychological education can promote mental health with competence. *Counselor Education & Supervision, 14*, 257–267.**

The author cites research indicating that competence is a necessary condition of mental health. Cognitive competence is defined as a crucial form of mastery, and attempts are made to show how it develops. Four conditions that psychological education curricula can provide to facilitate students' acquisition of cognitive competence are briefly outlined. ©APA.

432. **Laosa, L.M. (1979). Social competence in childhood: Toward a developmental, socioculturally realistic paradigm. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 253–279). Hanover, NH: University Press of New England.**

In this chapter, the author integrates several developmental theories to present a definition of social competence intended to be relevant to any culture. He attempts to identify means by which any society can maximize its children's acquisition of culturally valued psychosocial competencies at each developmental stage. Implications for primary prevention are integrated into the material on universal characteristics of social competence.

433. **Rae-Grant, Q.A.F., Gladwin, T., & Bower, E.M. (1966). Mental health social competence and the war on poverty. *American Journal of Orthopsychiatry, 36*, 652–664.**

It is proposed that a crisis has been precipitated within the mental health professions by the "war on poverty." This represents a crisis because the target population in this societal endeavor is composed of those people whom the "helping" professions have not yet figured out how to help. For the mental health field, the goal is to develop social mechanisms that will give to persons formerly deprived or incapacitated the means to reach out and grasp the opportunities that society offers them. Yet many agencies have withdrawn almost entirely from engagement with lower-class clients. The mental health field's responsibility to promote social competence rather than to solely "cure" established personality dysfunction is discussed, and some relative advantages of educational and mental health strategies are presented.

434. **Ricks, D.F. (1980). A model for promoting competence and coping in adolescents and young adults. In L.A. Bond, & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competence and coping during adulthood* (pp. 130–149). Hanover, NH: University Press of New England.**

The author addresses some of the physiological, psychological, and social changes that take place during adolescence which make this developmental period a special time of risk for disorder but also afford special opportunities for help. After summarizing some of the main changes and life events that adolescents go through, such as separation from parents and developing a career, the author presents a model that describes ways in which "life events may interact with the special strengths and vulnerabilities of adolescents to produce well-being and competence, or disorder, functional disturbance, and disability." The model posits that one's level of mental health is related to negative life change events. The author describes the progression of disability in adolescents as moving from protest to despair to apathy with a concomitant increase in the seriousness of the diagnostic label attached to the youth's disorder. Methods of effectively intervening with adolescents who are at high risk for developing schizophrenia are suggested.

435. **Rubin, E.Z. (1970). A psychoeducational model for school mental health planning. *Journal of School Health, 40,* 489–493.**

In discussing preventive and therapeutic programs to deal with emotionally disturbed children, an alternative model based on recent studies is set forth that can help school personnel implement programs of early identification, screening, and remediation. The adoption of a social competence model by school workers provides a method of identification that can be introduced very early in a child's life. Identification of high-risk subjects and the institution of retraining experiences can bring about a reversal of specific dysfunction and reduce vulnerability to maladjustment. Schools should include programs of readiness skill training at preschool, kindergarten, or first-grade level and specialized retraining programs in the later elementary grades supplementary to regular class instruction. Parent counseling is also considered an essential ingredient. Teachers and parents can be better informed of what to realistically expect from individual children and, rather than contribute to patterns of avoidance and discouragement, they can through their understanding provide support through appropriate attention to dysfunction. In this way the climate in which the child grows and the environment in which he/she learns can adapt to variability in capacity, avoiding the development of serious learning and emotional problems. (Author abstract modified)

436. **Sigel, I.E. (1979). Consciousness raising of individual competence in problem solving. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 75–96). Hanover, NH: University Press of New England.**

The aim of this chapter is to present a conceptual framework which, when put into operation, yields a class of behaviors hypothesized to influence the awarenss of self as a problem-solving individual. The relevant research literature in support of this hypothesis is discussed. Practices are described that have demonstrated an impact on young (preschool) children. Recommendations are offered for procedures that can be employed by teachers, parents, and clinicians to enhance self-awareness. These include distancing strategies, open-ended inquiry, and encouraging engagement in the problem-solving process.

437. Smith, M.B. (1974). Competence and adaptation. *American Journal of Occupational Therapy, 28*, 11-15.

The role of "metapsychological" assumptions about the nature of man in guiding educational and therapeutic strategies is briefly discussed, and an emerging metapsychology of the concept of competence is proposed as being consistent with evidence on human behavior, development, and experience. This concept is succinctly defined as humans' tendency to want to use their capacities to produce effects on their environment. This inherent tendency is shaped by developmental experience, and is therefore subject to both tampering or enhancement, largely through a process of self-confirmation of one's self-concept. Thus, it is proposed that fostering the attitudes of self-respect as a significant and efficacious person and of hopefulness toward the world as a place where one can be efficacious is essential to initiating the spiraling process of increased competence and fulfillment. This model suggests some broad therapeutic strategies for the special kind of help intended to foster competence: respectful, close attention; sustaining yet tough-minded faith by the therapist in the client's human potential; properly paced developmental tasks; and exposure to appropriate models.

438. **Suomi, S.J. (1979). Peers, play, and primary prevention in primates. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 127-149). Hanover, NH: University Press of New England.**

The development of social competence in young rhesus monkeys is explored with special emphasis on the role played by peers in individual subjects' acquisition of social skills. Two somewhat paradoxical sets of findings are examined: (1) the overwhelming importance of peer relationships in the development of social skills and assignment of social roles and (2) crucial relationships with peers as exceedingly fragile and easily disrupted, often with disastrous consequences for the furthering of social competence. It is argued that warm, stable, secure social environments foster the establishment of appropriate peer relationships, which in turn define the individual's competence as an adult. Implications of the findings are discussed in terms of peer relationships as the least robust element in the chain leading to social competence; social incompetence as a threat to the well-being of others in the immediate social environment; evaluation of peer interactions as a diagnostic tool for certain forms of monkey psychopathology; and the applicability of monkey findings to humans.

439. Swisher, J.D. (1976). Mental Health--the core of preventive health education. *Journal of School Health, 46,* 386-391.

A scientifically derived approach to preventive health education that places individual, emotional development at the core of the curriculum is presented. The major assumption underlying this mental health education model is that enriched emotional development will prevent a variety of health problems. If this assumption is true, then it follows that the health curricula in the schools should expose students to a core of affectively enriching experiences. These experiences should be goal oriented (for example, improved self-concepts), and planned in a systematic fashion. It would be inappropriate to advocate the wholesale adoption of a particular affective mode (for example, value sharing). Instead, what is needed is the development of a comprehensive and multifaceted program. Furthermore, it is contended that a health education program of preventive measures should be designed to faciliate the personal development of students at all grade levels in order to offset the epidemiological factors that contribute to various health problems. The four major dimensions of the model (personal skills, interpersonal skills, extrapersonal skills, and health problems skills) are discussed. (Author abstract modified)

440. White, R.W. (1959). Motivation reconsidered: The concept of competence. *Psychological Review, 66,* 297-333.

This article is considered by many to be a breakthrough and a classic in the development of the concept of competence. The author's dissatisfaction with the respective drive theories of Freud and Hull led to the consideration of the concept of competence in attempting to better understand motivation. Competence is seen as an innate biological and psychological attribute of humans to interact effectively, that is, to learn to master and exert an influence on the environment. The author argues that "the motivation needed to attain competence cannot be wholly derived from sources of energy currently conceptualized as drives or instincts." This article's relevance to primary prevention lies in its significance in the development of the concept of competence.

441. White, R.W. (1979). Competence as an aspect of personal growth. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 5-22). Hanover, NH: University Press of New England.

The author introduces this volume by summarizing his views on the promotion of social competence. He suggests that competence is primarily a biological concept--that humans have an urge to act effectively on the environment. A primary factor in developing competence is how rewarding one's behavioral initiatives are to the individual. Becoming socially competent requires the experience of success in social initiatives. He suggests that if competence is self-initiated, self-rewarded, and implies value judgments, the role of outside agencies in promoting it is questionable.

442. **Zigler, E., & Trickett, P.K. (1979). The role of national social policy in promoting social competence in children. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 280-296). Hanover, NH: University Press of New England.**

The authors provide an overview of the ways in which developmental and educational theories have recently influenced policies of the United States Government and how the theories, in turn, have been affected by these policies. The authors stress the importance of evaluating the long-term effects of interventions such as Head Start and Follow Through. An adequate social competence index must be developed. Such an index would include measures of physical health and well-being, formal cognitive ability, achievement, and emotional motivational variables. These indices should be used in evaluating progress in the primary prevention field.

See also: 9, 20, 53, 54, 62, 72, 73, 74, 97, 158, 273, 294, 349, 364, 443, 444, 488, 496, 723.

B. Competence Building with Children and Adolescents

Due to the very nature of primary prevention, it is sensible to begin teaching individuals at an early age competencies which might make them more competent and more resistant to developing psychopathology. Preschool and grade school age children have received the greatest amount of attention in this area followed by junior high and high school age adolescents. This section has been divided into four categories according to the type of competence or skill being taught. The first category involves the teaching of interpersonal or social problem-solving skills to children and adolescents. The second category includes articles dealing with interventions to improve primarily the cognitive or academic skills of youths. The third category includes descriptions of interventions that have attempted to teach a variety of mental health education, self-growth related competencies to children and adolescents. Such skill-buildling attempts have involved the teaching of self-awareness, self-control, coping with stress, counseling skills, and coping with failure. The fourth and final category in this section includes articles that describe the teaching of social skills designed to help youths learn to enhance their social relationships.

1. Interpersonal and Social Problem-Solving Competence Building

443. **Durlak, J.A. (1983). Social problem-solving as a primary prevention strategy. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 31-48). New York: Pergamon Press.**

Social problem-solving programs are described, categorized, and reviewed for their measured effectiveness. Categories of problem-solving programs include those described as cognitive, developmental, or task-specific. In evaluating current programs, the author cites the lack of a clearly documented long-term causal relationship between problem-solving and mental health. Furthermore, programs cannot claim success in terms of primary prevention. However, the area of problem-solving programs is praised for its solid theoretical underpinnings. Three competing theoretical models are discussed.

444. **Forquer, S.L. (1982). Developing coping skills in early childhood: Theory and techniques. *Journal of Children in Contemporary Society, 14*, 43-47.**

The author proposes techniques for fostering the development of coping skills in early childhood. The differences between pseudoimmunity to stressful events vs. psychological immunity are highlighted. Emphasis is placed on the role of problem-solving skills in preschool populations. The introduction of new challenges in manageable dosages is encouraged. ©APA.

445. **Gesten, E. L., Flores-de-Apodoca, R., Rains, M., Weissberg, R. P., & Cowen, E. L. (1979). Promoting peer-related social competence in schools. In M. W. Kent, & J. E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 220-247). Hanover, N. H.: University Press of New England.**

Social problem-solving (SPS) in the schools was promoted in a pilot study (1976 to 1977) in which nine teachers from middle-class suburban schools were trained to implement the SPS program to second- and third-grade classes. The SPS curriculum required students to examine feelings, identify problems, generate alternative solutions, consider the consequences of these solutions, and generalize the SPS approach to the classroom and other real life problems. Preliminary findings show that the program was well received by the students and teachers, that children responded well to videotapes of other children using techniques, that children used problem-solving skills outside the classroom, that class management problems diminished as children became better able to solve their own problems, and that children brought personal problems to school because of the increased rate of separation and divorce among their parents.

446. **Gesten, E.L., Rains, M.H., Rapkin, B.D., Weissberg, R.P., Flores-de-Alpodoca, R., Cowen, E.L., & Bowen, R. (1982). Training children in social problem-solving competencies: A first and second look. *American Journal of Community Psychology, 10*, 95–115.**

The effects of a 17-lesson, classroom-based, social problem-solving (SPS) training program for 201 second- and third-grade suburban children were assessed after the 9-week intervention and in a 1-year followup. Three training conditions included a structured, full-package curriculum that emphasized role-playing, modeling, and discussion (E1); an abbreviated modeling, videotape-only curriculum (E2); and a no-treatment control group (C). Outcome measures examined both problem-solving skill acquisition and behavioral adjustment. At posttesting, subjects exposed to the full-package curriculum improved more than both the videotape-only groups and controls in social problem-solving skills, i.e., in alternative and consequential thinking and in solving a simulated behavioral peer problem. Adjustment results, by contrast, generally indicated improved teacher-rated performance for the controls over one or both experimental conditions. At followup, the full-package group maintained their advantage over both comparison groups on consequential thinking. Experimentals performed better than controls on 7 of 10 teacher-rated competence and pathology factors and 2 sociometric indices. Findings highlight the potential benefits of the preventive model as well as the need for both short- and longer-term evaluations. More study is required to clarify the nature of possible linkage(s) between problem-solving and adjustment in latency-aged children. (Author abstract) ©Plenum Publishing Corp.

447. **Jason, L.A., & Ferone, L. (1981). From early secondary to primary preventive interventions in schools, *Journal of Prevention, 1*, 156–173.**

A 4-year research effort, aimed at developing preventive educational interventions for children in inner-city schools, is described. The initial thrust of the programs was toward secondary prevention: identifying early childhood disorders and formulating consultation interventions to remediate the problems. Over time, the direction of the projects changed from an early secondary to a primary preventive orientation. In these later interventions, entire classes or groups of children were provided skill-building experiences (e.g., social skills, problem-solving techniques, or peer tutoring skills). Other children were involved in programs designed to prevent the onset of smoking. Still others were provided skills to master critical developmental transitions. Examples of these latter preventive interventions included providing behavior management skills to a first time teacher in a first grade classroom, an orientation program to children transferring to a new school, and teaching public speaking skills to children entering high school. The implications of switching the emphasis from early secondary to primary preventive programs are discussed. (Author abstract) ©Human Sciences Press.

448. Sarason, I.G., & Sarason, B.R. (1981). Teaching cognitive and social skills to high school students. *Journal of Consulting and Clinical Psychology, 49*, 908–918.

Modeling and role playing were used in an effort to strengthen the cognitive and social skills of students in a high school with high dropout and delinquency rates. A control group was compared with subjects who participated in live or videotaped modeling. Subjects who received special training were able to (a) think of more adaptive ways of approaching problematic situations and (b) perform more effectively in a self-presentation situation (job interview). In addition, in a 1-year followup, they tended to show lower rates of tardiness and fewer absences and behavior referrals. The research suggests a potentially useful and cost-effective approach to the prevention of behavioral problems. (Author abstract) ©APA.

449. Schinke, S.P., & Gilchrist, L.D. (1977). Adolescent pregnancy: An interpersonal skill training approach to prevention. *Social Work and Health Care, 3*, 159–167.

A pilot study of an interpersonal skill training model for sexually active inner-city adolescents was examined. The model was designed to help adolescents develop responsible sexual and contraceptive behavior and prevent pregnancy. One male and nine female adolescents voluntarily participated in a pilot interpersonal skill training group. Role-playing was used to aid the students in self-assertion in male/female dyadic interactions. Student responses to the pilot program were consistently positive. It is concluded that such training is a promising direction for future pregnancy prevention efforts in the adolescent target population.

450. **Schinke, S.P., Blythe, B.J., & Gilchrist, L.D. (1981). Cognitive-behavioral prevention of adolescent pregnancy.** ***Journal of Counseling Psychology, 28,*** **451–454.**

Cognitive and behavioral methods were applied to assist adolescents with avoidance of unplanned pregnancy. Small group training gave high school sophomores contraceptive information, steps for solving problems, and practice in communicating decisions about sexual behavior. Compared with untrained, control condition teenagers, trained teenagers had more positive posttest scores on measures of sexual knowledge, interpersonal problem-solving, and in vivo performance. At a 6-month followup, young women and men who participated in training groups had better attitudes toward family planning and were practicing more effective contraception than young people in control conditions. It is suggested that the findings have implications for cognitive and behavioral counseling aimed at the primary prevention of personal and social difficulties faced by young people. (Author abstract modified)

451. **Shure, M.B. (1979). Training children to solve interpersonal problems: A preventive mental health program. In R.F. Munoz, L.R. Snowden, & J.G. Kelly, (Eds.),** ***Social and psychological research in community settings*** **(pp. 30–68). San Francisco: Jossey-Bass.**

The author provides an overview of her own and her colleagues' research in the area of training children to solve interpersonal problems as a means of primary prevention. Background research is first discussed with an emphasis placed on the assumption that interpersonal cognitive problem-solving (ICPS) skills are an antecedent condition for healthy social adjustment. The author then reviews her research intervention involving the teaching of ICPS skills to lower socioeconomic class children found to be deficient in these skills relative to middle-class age-mates. In addition to the training of children, mothers were taught ICPS skills so that they might serve as models. The training sites, training procedures, evaluation measurement instruments, and evaluation results are briefly reviewed. Results generally indicate that 4- and 5-year-olds can be taught ICPS skills and that the acquisition of these skills leads to better behavioral adjustment than in control children who are not taught them. Next, the author discusses in detail the steps that were necessary to develop this research program from idea to pilot program to full-scale preventive research intervention. Finally, Myrna Shure is interviewed by one of the book's editors to give her personal reflections about her research.

452. Shure, M.B., & Spivack, G. (1978). *Problem-solving techniques in childrearing*. San Francisco: Jossey-Bass.

A research program aimed at training mothers to teach interpersonal cognitive problem-solving skills to their children is presented. Issues addressed include how a mother can stimulate the development of ICPS skills in her child; which parental ICPS skills are most critical in the child's interpersonal problem-solving development; and ways in which training both the mother and the child ultimately affects the child's ability to deal with other people. The use of mental health workers and others in training parents to use these procedures is discussed. Finally, evidence on the effects of the program, including how the mother's thinking skills change and how that change influences the child's thinking skills and behavior, is presented.

453. Shure, M.B., Spivack, G., & Gordon, R. (1972). Problem-solving thinking: A preventive mental health program for preschool children. *Reading World, 11*, 259-273.

To enhance cognitive interpersonal problem-solving skills and behavioral adjustment for disadvantaged preschoolers, 50 training sessions were conducted using 28 male and 26 female 4-year-old Ss. Twenty-two Ss were trained, 11 received "special attention" but no training, and 21 Ss comprised the "no-treatment" group. Equated on pretest scores on the major dependent variables and measured IQ, a significantly greater number of trained Ss increased their problem-solving score (irrespective of IQ), and showed a definitive trend toward increased ability to delay gratification. Trained Ss who improved most in problem-solving scores also improved most on measures of behavioral adjustment. It is concluded that 4-year-old disadvantaged children can be guided to think in such a way as to consider alternative solutions to real-life problems. ©APA.

454. Shure, M.B., & Spivack, G. (1979). Interpersonal cognitive problem solving and primary prevention: Programming for preschool and kindergarten children. *Journal of Clinical Child Psychology, 8*, 89-94.

A competence building model of primary prevention was evaluated on 131 inner-city Black nursery and kindergarten children. The major question for evaluation was whether enhancing interpersonal cognitive problem-solving (ICPS) skills of 4- and 5-year-olds could improve inhibited and impulsive behaviors when they already exist, and prevent them from emerging when they do not. Findings suggest that ICPS training does reduce and prevent such behaviors. Followup data show that ICPS and behavioral impact of such programming lasts at least 1 full year following intervention. The program works for children who are not exposed to it before kindergarten. However, more children do begin kindergardten at a better behavioral vantage point if ICPS programming is implemented at the nursery level.

455. Shure, M.B., & Spivack, G. (1979). Interpersonal problem solving thinking and adjustment in the mother-child dyad. In M.W. Kent, & J.E. Rolf, (Eds), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 201-219). Hanover, NH: University Press of New England.

The ICPS approach to childrearing was explored with 40 black mother-child pairs. The study was designed to determine: (1) whether training increased mothers' ICPS skills, (2) if mothers' ability to guide their children in solving real problems could be enhanced, and (3) how change in mothers' problem-solving thinking and childrearing style affect their children's ICPS ability and/or school behavioral adjustment. Results showed that ICPS training clearly improved impulsive behavior of inner-city 4-year-olds; children exposed to ICPS training in one environment (the home) improved in their behavior as observed in a different one (the school); inner-city mothers could successfully improve their own skills as well as those of their children in only 3 months; and impulsive behaviors similar to those measured in young children were slower to change in older children. Implications for the prevention of social incompetence are discussed.

456. Shure, M.B., & Spivack, G. (1980). Interpersonal problem solving as a mediator of behavioral adjustment in preschool and kindergarten children. *Journal of Applied Developmental Psychology, 1*, 29-44.

An experimental model tested the mediating function of interpersonal cognitive problem-solving skills on behavioral adjustment in preschool and kindergarten children. Relative to controls, nursery-trained youngsters improved in three such skills, kindergarten-trained in two. In both the nursery- and kindergarten-trained groups, increased ability to conceptualize alternative solutions to interpersonal problems significantly related to improved social adjustment. Consequential thinking also emerged as a clear behavioral mediator, especially among kindergarten-aged youngsters. Improvement in behavior could not, however, be attributed to change in causal thinking skills. Having identified two significant behavioral mediators in young children, a beginning has been made to isolate specific thinking skills, which, if enhanced, can contribute to healthy social adjustment and interpersonal competence at an early age. (Author abstract)

457. **Shure, M.B., & Spivack, G. (1981). The problem-solving approach to adjustment: A competency-building model of primary prevention. *Prevention in Human Services, 1,* 87–103.**

A competency building model of primary prevention, the interpersonal cognitive problem-solving training approach, is described. As social maladjustment, to a significant extent, is a function of the individual's inability to effectively identify and solve problems of an interpersonal life situation, the training approach was developed to enhance social adjustment and interpersonal competence by increasing interpersonal problem-solving abilities. Emphasis is placed on enhancing the trainees' abilities to: generate problem solutions, determine suitable means of achieving end goals, and recognize the consequences of alternate strategies. Research results and program evaluation indicate the validity and viability of this approach for children as young as 4 and 5, as well as for older children. (Author abstract modified)

458. **Shure, M.B., & Spivack, G. (1982). Interpersonal problem-solving in young children: A cognitive approach to prevention. *American Journal of Community Psychology, 10,* 341–356.**

An interpersonal cognitive problem-solving (ICPS) intervention, designed to reduce and prevent impulsive and inhibited behaviors in black low socioeconomic status (SES) 4- and 5-year-olds, was implemented by teachers and evaluated over a 2-year period. In the first year, 113 children were trained and 106 were not. The 131 still available in kindergarten were divided into four groups: twice-trained (n=39); once-trained, nursery (n=30); once-trained, kindergarten (n=35); and never trained controls (n=27). Findings showed that (a) ICPS impact on behavior lasted at least 1 full year, (b) training was as effective in kindergarten as in nursery, and (c) for this age and SES group, 1 year of intervention had the same immediate behavior impact as 2. Further, well-adjusted children trained in nursery were less likely to begin showing behavioral difficutlies over the 2-year period than were comparable controls, highlighting implications of the ICPS approach for primary prevention. (Author abstract) ©Plenum Publishing Corp.

459. **Spivack, G., Platt, J.J., & Shure, M.B. (1976). *The problem-solving approach to adjustment: A guide to research and intervention.* San Francisco: Jossey-Bass.**

The role of interpersonal problem solving and social cognition in human adjustment is discussed. Evidence for the importance of specific cognitive skills in relationship to problem solving during early childhood, middle childhood, adolescence, and adulthood is presented. The possible role of family and childrearing practices in the development of interpersonal problem-solving skills is discussed. Finally, specific programs applying problem-solving training techniques to diverse populations such as psychiatric patients and hyperactive children are examined.

460. **Spivack, G., & Shure, M.B. (1977). Preventively oriented cognitive education of preschoolers. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 79–82). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

A preventively oriented interpersonal cognitive problem-solving skills (ICPS) program for kindergarten children is summarized. The ICPS program is designed to teach those cognitive skills found to distinguish children with behavioral problems from those without. Cognitive skills including alternative thinking, consequential thinking, causal thinking, and cognitive sensitivity were taught to 113 nursery and kindergarten children by the teacher or mother through games and dialogue sessions for a 10-week period. Nursery children received an additional 10-week training course during kindergarten. Analysis of data indicated: (1) significant training effects for adjusted youngsters and greater effects for impulsive and inhibited children; (2) ICPS improvement relates directly to behavioral improvements; (3) improvements in adjustment are maintained through kindergarten and first grade; (4) mothers and teachers are equally effective trainers; and (5) greatest improvement occurred in alternative and consequential thinking.

461. **Stone, G.L., Hinds, W.C., & Schmidt, G.W. (1975). Teaching mental health behaviors to elementary school children. *Professional Psychology, 6,* 34–40.**

This paper reports a study designed to support the expansion of developmentally oriented, preventive programs and services as functions of elementary school counselors. A preventive program was developed based on principles of social learning. Children were provided with models demonstrating behaviors to be learned through presentation of stimulus videotapes. Three hypotheses tested stated that teaching elementary school children problem-solving procedures will increase their frequency of: seeking information, generating alternatives, and setting personal goals when dealing with a problem. Subjects were third, fourth, and fifth grade children of two urban elementary schools of the Lansing, Michigan, school system. Pretest comparisons between treatment and control groups indicated that none of the chi-square values were significant. Posttest values indicated significant differences between the control and experimental groups on the generation of facts, choices, and solutions. It is concluded that specific problem-solving skills can be taught to elementary school children. Some implications in support of developmental, preventive programs are discussed.

462. **Urbain, E.S., & Kendall, P.C. (1980). Review of social cognitive problem solving with children. *Psychological Bulletin, 88*, 109–143.**

This article critically reviews training studies of interpersonal problem solving, family problem solving, verbally mediated self-control applied to social behavior, and social perspective taking with children. Treatment procedures are described, and the outcome data are examined. Although some encouraging results have been reported, the need for assessing behavioral adjustment, for better control group procedures, and for more long-term followup reports are particularly noted. The discussion also considers the need to examine specific deficits in social-cognitive abilities, the similarities across different training programs, and the need for analysis of the active treatment ingredients in multifaceted training programs. (Author abstract) ©APA.

463. **Weissberg, R.P., Gesten, E.L., Rapkin, B.D., Cowen, E.L., Davidson, E., Flores-de-Apodaca, R., & McKim, B.J. (1981). Evaluation of a social-problem-solving training program for suburban and inner-city third grade children. *Journal of Consulting and Clinical Psychology, 49*, 251–261.**

The effects of a 52-lesson, class-taught, social-problem-solving (SPS) training program for third-grade children were assessed with three questions in mind: (a) Does training improve interpersonal problem-solving abilities? (b) Does it enhance behavioral adjustment? and (c) Are problem-solving and adjustive gains related? A total of 243 suburban and inner-city program children and controls were evaluated on a variety of problem-solving and behavioral-adjustment measures. Program children improved more than controls on several cognitive skills, including problem identification, alternative solution thinking, and consequential thinking as well as on behavioral problem-solving performance. The intervention positively affected the adjustment of suburban but not urban younsters. However, relationships between problem-solving skill improvements and adjustive gains were not found. Variables such as program curriculum and the age and sociodemographic attributes of its targets must be better understood in exploring the potential of SPS training to promote behavioral adjustment. (Author abstract) ©APA.

464. **Winer, J.I., Hilpert, P.L., Gesten, E.L., Cowen, E.L., & Schubin, W.E. (1982). The evaluation of a kindergarten social problem solving program.** ***Journal of Primary Prevention*, *2*,** **205–216.**

The present study evaluated the effectiveness of a Social Problem Solving (SPS) competence training program for kindergartners, and examined relationships between SPS skill and adjustment gains. Subjects included 63 suburban middle-class Ss from three classes that participated in the 42-lesson program, and 46 comparison Ss from two classes that did not. Subjects were evaluated on problem-solving, peer sociometric, and teacher adjustment ratings. Program children gave significantly more, and better, solutions and fewer irrelevant responses to interpersonal problems. They also improved more than comparison Ss on several teacher-rated dimensions of adjustment. Direct linkages between skill and adjustment gains, however, were not found. (Author abstract) ©Human Sciences Press.

See also: 20, 102, 131, 436, 656, 858, 904.

2. Cognitive and Academic Skills Competence Building

465. **Jason, L.A. (1977). A behavioral approach in enhancing disadvantaged children's academic abilities.** ***American Journal of Community Psychology*, *5*,** **413–421.**

Economically disadvantaged toddlers, aged 12–24 months, manifesting social and behavioral difficulties, were identified at a health care facility in Rochester, New York. Such children were randomly assigned to two groups, the first of which participated in an intervention program from September to December, the second group from January to April. Parents were exposed to the program through instructions and modeling during the home sessions and participated in meetings to discuss childrearing problems and techniques and to increase their feelings of competence and mastery. Target children registered significant academic gains following program participation, whereas without the program, skills remained constant. Children in the first semester program were found to have maintained their gains at a followup 3 months after the program had ended. Parent involvement and participation was considered to be an active factor in gain maintenance. (Author abstract) ©Plenum Publishing Corp.

466. **Myers, E.O. (1974). Doing your own think: Transmission of cognitive skills to inner-city children. *American Journal of Orthopsychiatry, 44*, 596–603.**

Think Workshops, which train Harlem parents to experience "fun in thinking" with their children, are described. The program of Project Search for Preventive Approaches (SPA) is reported, emphasizing the development of cognitive competence in inner-city youngsters as a pleasurable form of ego satisfaction and as a possible deterrent to a delinquency-prone behavior. Cognitive fun and games workshops for adults were instituted. Brainstorming as an ego-oriented rather than a task-oriented technique helped provide parents, paraprofessionals, and children with ego strengthening flexibility. Significant gains in cognitive skills by both adults and youngsters were noted. (Author abstract modified)

467. **Samuels, S.C. (1981). Long-term effects of early childhood educational enrichment programs: Preventive implications. *Journal of Preventive Psychiatry, 1*, 57–75.**

The short- and long-term effects of early childhood intervention programs based on educational enrichment are reviewed, beginning with the advent of Head Start in 1965. Research is summarized relating to the effects of intervention on children's cognitive and social emotional development and health. The history of the program and methodological problems of research completed in the early years are discussed. Improved research designs in recent followup studies have enabled researchers to collect data showing significant cognitive differences years after early intervention. Relationships are examined among various psychological variables, parental involvement in programs, program components, length of intervention, and children's cognitive gains. Gains have been found in academic motivation, confidence, and adaptive ability for high quality early childhood programs meeting set goals. Special education placement and grade retention later in school have also been found. The few studies assessing affective change have found significant differences in this area. Parental participation, infancy programs, and lengthy interventions were positively related to cognitive growth. The preventive role of early educational intervention appears to be large in terms of decreasing children's developmental problems, providing social services and jobs for their families, and, presumably, in reducing costs of remediation, special education, child abuse, and welfare programs. (Author abstract modified)

468. **Scott, R. (1976). Home-start: Third grade followup assessment of a family-centered preschool enrichment program.** ***Psychology in the School, 7,*** **435-438.**

This study compared third-grade achievement test scores of participants in Vertical Home Start (VHS), a preschool individualized program for children from 2 to 5 years of age, with comparable scores of their older and nonprogram siblings. Nonparametric rank ordering assessment revealed significant trends for black VHS children to attain higher rankings on 11 of the 15 subtest measures; no significant ranking differences were obtained with white children. Results indicate that, especially for black children, home-based preschool enrichment may more effectively promote growth in math and basic skill areas related to Cattell's crystallized intelligence, with more limited enrichment effects in such language-linked subject areas as vocabulary and reading. (Author abstract)

See also: 374, 375, 576, 431, 448.

3. Competence Building Through Mental Health Education

469. **Bedrosian, O., Nathir, S., & Pearlman, J. (1970). A pilot study to determine the effectiveness of guidance classes in developing self-understanding in elementary school children.** ***Elementary School Guidance and Counseling, 5,*** **124-134.**

The project aimed at developing, implementing, and evaluating a developmental guidance program designed to meet the guidance needs of elementary school children. The general objective was to stimulate children to gain insights into their behavior and that of their peers, siblings, parents, and teachers. Responses from children, teachers, counselors, and parents were enthusiastic and positive. Empirically, it was found that an instructional program in guidance helps prevent accumulation of pressures and frustrations and contributes toward reduction of guidance needs of children. It was also established that regular classroom teachers trained in techniques of group interaction can be more effective in implementing an instructional program in guidance than school counselors.

470. **Bernier, J.E., and Rustad, K. (1977). Psychology of counseling curriculum: A followup study.** ***Counseling Psychologist, 6,*** **18-21.**

This paper describes the development of a base curriculum teaching counseling skills to high school pupils. It was contended that most of the remedial models for promoting human growth and development in problem students are not adequate to meet the needs of other adolescents. A primary prevention curriculum model based on a cognitive/structural framework, supported with practical suggestions, and substantiated by formative evaluation was therefore offered as an alternative. The intervention consisted of a course in counseling psychology available to high school juniors and seniors. It treated adolescence as a unique developmental stage between childhood and adulthood, emphasized that interaction and disequilibrium initiate cognitive/structural change, and offered the role-taking opportunities believed central to moral development. Evaluation followed a pretest/posttest, nonequivalent comparison group design and included a 1-year followup. Results suggested that the psychology of counseling as a regular curriculum course based on cognitive/developmental theory will promote positive growth in adolescence.

471. **Cooper, S., Munger, R. & Ravlin, M.M. (1980). Mental health prevention through affective education in schools.** *Journal of Prevention, 1,* 24-34.

The trend toward mental health prevention through affective education is discussed. The emphasis in affective education is on the prevention of impairments predictable in the absence of intervention and on the promotion of coping strength. Various approaches to affective education include large group discussion, confluent education, small group discussion, growth and development courses, personal and interpersonal adjustment courses, values clarification, moral education communication and group process skills, behavioral science and psychological curricula, life space interview, decisionmaking and problem-solving, and a self-control curriculum. Three main areas of concern, child-centered, teacher-centered, and systemic concerns, are addressed.

472. **Cooper, S., & Seckler, D. (1973). Behavioral science in primary education: A rationale.** *People Watching, 2,* 37-39.

Arguments for including behavioral science courses in the primary school curriculum as a preventive mental health measure are discussed. Teaching units based on a psychodynamic understanding of the developmental tasks and issues facing children at each age level were developed and applied in an elementary school, with the aid and support of the local mental health clinic. It was found that students responded to the materials and requested more lessons in the area; class participation ran very high; and both students and faculty found the program a learning experience.

473. **Dinkmeyer, D. & Ogburn, K.D. (1974). Psychologists priorities: Premium on developing understanding of self and others. *Psychology in the Schools, 11,* 24–27.**

Preventive programs to fight mental disorders in schools, with emphasis on family involvement, are described. The relationship between personality factors such as self-concept and academic achievement is justification for the school psychologist to influence the curriculum to meet the child's emotional needs. A program called Developing Understanding of Self and Others was designed to develop self-understanding and acceptance and to foster social relationships among peers. The basic approach of the program is experimental and emphasizes learning through active participation on the part of the child, parent, and teacher.

474. **Engel, R. (1982). A psychoeducational approach to coping with failure amongst pupils. *School Psychology International, 3,*** 231–235.

In a discussion of the need for a method to provide individuals with ways of coping with failure, the connection between psychopathology and failure is explored, specifically in relation to its manifestation in the educational system. A gestalt-oriented, primary prevention model for helping students understand and cope with failure is outlined. The model includes creative writing, art, and simulation play components. Implications for teacher training are also noted. ©APA.

475. **Fagen, S.A., Long, N.J., & Stevens, D.J. (1975). *Teaching children self-control: Preventing emotional and learning problems in the elementary school.* Columbus, OH: Charles E. Merrill.**

The author presents a three-part, structured, integrated curriculum for the development of self-control. Part 1 presents the theoretical and conceptual structure upon which the curriculum is based. Part 2 describes the eight curriculum areas and their subsidiary units and tasks. Part 3 describes important issues pertaining to self-control curriculums in general. ©APA.

476. **Griffin, J.D. (1968). Public education and school procedures. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders.* Toronto: University of Toronto Press.**

The author reviews some attempts made in recent years to protect and promote the mental health of children and adults through educational methods. Since it deals with all children, the school is in a position to be of great assistance in primary prevention. The value of kindergarten and prekindergarten classes has been demonstrated frequently with regard to correcting the effects of social and cultural deprivation. A number of programs have been implemented in elementary and junior high schools. The author discusses some obstacles in the way of primary prevention in the schools, including the school's contribution to psychiatric problems and resistance of administrators, teachers, and school board officials. Other efforts at public education as a preventive measure have been attempted, with inconclusive results.

477. **Hartley, W.S. (1977). Preventive outcomes of affective education with school age chidlren: An epidemiologic followup of the Kansas City School Behavior Project. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 69–75). (DHEW Pub. No. (ADM) 77–477). Washington, DC: U.S. Government Printing Office.**

Preventive outcomes of an affective education program for Kansas City school age children are summarized. The Kansas City School Behavior project, designed to enhance the social/affective development of sixth grade pupils utilizing the teacher as resource person and group member, was derived from concepts in educational sociology, group dynamics, psychology, and psychotherapy. A 3-year followup study of pupils involved in the program indicated a prevention effect for program pupils compared to controls in school absence rates and in police and juvenile court data. It is suggested that the prevention effect is real, lasting, and generalizable to the community and can be obtained by incorporating small group programs into the classroom. Teacher training, program problems, and recommendations for future programs are also discussed.

478. **Hartman, L.M. (1979). The primary prevention of behavior pathology: An empirical investigation. *Psychiatric Journal of the University of Ottawa*, *4*, 260–267.**

Part 1 examines current approaches to prevention in mental health and reviews a study conducted within the framework of a behavioral model. Available paradigms for conceptualizing preventive operations include the "psychogenic hypothesis," the preservation of normality, and behavioral prophylaxis. An empirical model for detecting populations at psychological risk is proposed. Part 2 outlines an empirical study in which asymptomatic 9th and 10th graders undergoing preventive intervention showed greater gains than control Ss on self-report, peer, and teacher rating measures of self-esteem, psychological discomfort, assertiveness, and social skills. These improvements in risk profiles were also evident at a 3-month followup. Results support a response acquisition approach for the preventive attentuation of behavioral indices that presage serious maladjustment. ©APA.

479. **Long, B.E. (1970). Behavioral science for elementary school pupils. *Elementary School Journal, 70,* 253–260.**

A group of elementary school children, mostly at sixth grade level, were instructed in behavioral science for a full school year. As a consequence of this experiment, it is suggested that this sort of instruction, at this age level, may help prevent future emotional disturbances and student unrest. At this age, children are too young to understand theory, but they respond enthusiastically to group experiments that demonstrate psychological principles. In the year's experiment, heavy emphasis was placed on practical applications of these psychological principles to the children's real life experience. No formal evaluation of accomplishment was conducted.

480. **Morgan, C., & Jackson, W. (1980). Guidance as a curriculum. *Elementary School Guidance and Counseling, 15,* 99–103.**

A prevention-oriented, developmental guidance program curriculum for elementary school children is outlined. In addition to cognitive goals, such a program should include affective and psychosocial goals, including facilitation of children's trust in self and others; ability to develop goals and planning for the future; understanding of freedom within necessary constraints; more stable self-image; and confidence and security through feelings of competence and self-esteem. Within the context of these goals, measurable, hierarchically linked objectives were developed within common skill areas. Eight major clusters of outcomes were identified: awareness of feelings, valuing decisionmaking, behavior causes, listening, cooperation and conflict resolution, occupational and educational decisionmaking, and classroom management. Instructional guides were then developed for use by teachers in developing specific objectives.

481. **Moskowitz, J.M., Schaps, E., & Malvin, J.H. (1982). Process and outcome evaluation in primary prevention: The magic circle program. *Evaluation Review, 6,* 775–788.**

The authors evaluated Magic Circle, a primary prevention strategy aimed at fostering positive self-esteem and attitudes connected with school. Fourteen teachers and 102 male and 115 female third graders served as experimentals; another 14 teachers and 131 male and 119 female third graders served as controls. Process evaluation indicated that although the teachers valued the training process and content and mastered most of the skills involved, the number of Circles they conducted varied considerably. At posttest, experimental teachers were more satisfied with teaching than their control counterparts. Analysis of class-level student data revealed higher social self-esteem but more minor discipline problems for experimental boys. Results were unrelated to amount of Magic Circle exposure. ©APA.

482. **Neal, R.B. (1981). Preparing health educators to teach mental health. *Journal of School Health, 51*, 597-600.**

Elements of a course in mental health education for undergraduate teachers in training are described. It is argued that the importance of mental illness prevention has not received proper emphasis in health education programs, and that a model based on Maslow's concept of the self-actualized individual and the healthy personality is useful as the basis of a course for students. Such a course aims at providing instruction in concepts, attitudes, and skills that will assist students in developing a mentally healthy classroom atmosphere. Additional emphasis is on an understanding of the importance of self-esteem, values clarification and decisionmaking, and techniques of health counseling.

483. **Ojemann, R.H. (1961). Investigations on the effects of teaching an understanding and appreciation of behavior dynamics. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 378-397). New York: Basic Books.**

Training children to develop a causal orientation toward the social environment is proposed as a means for mental health promotion. Methodology for changing the content of school programs and teacher-child interactions in a way that will improve knowledge of influences on human behavior is presented. Studies are cited that show the positive effects of "causal-thinking" programming on reducing punitiveness, anxiety, and intolerance for ambiguity. Implications of increased causal thinking for immediate individual and future generational benefits are discussed.

484. **Palomares, U.H., & Rubini, T. (1973). Human development in the classroom. *Personnel and Guidance Journal, 51*, 653-657.**

The implementation of a Human Development Program in a public school in which the school guidance counselor acted as a teacher trainer and consultant is described. The program is designed to give children the opportunity to develop an awareness of their positive and negative feelings and thoughts and constructive or destructive behaviors. Three themes are focused on: awareness (knowing feelings, thoughts, and actions); mastery (self-confidence); and social interactions (knowing others). The counselor's role in training, critiquing, coaching, and followup is discussed. The program helps children become better listeners, and they become more involved with each other and their teacher. Applications of the program to situations other than education are discussed.

485. **Roen, S.R. (1967). Primary prevention in the classroom through a teaching program in the behavioral sciences. In E. Cowen, E. Gardner, & M. Zax (Eds.), *Emergent approaches to mental health problems* (pp. 252–270). New York: Meredith.**

The author states that the school is an excellent place for programs of primary prevention since it comes into contact with all children. The author discusses two sustained approaches to primary prevention in the classroom: the "total school atmosphere emphasis" program of the Bank Street College group, which attempts to integrate the goals of education and mental health; and the improved curriculum emphasis of Ojemann, which restructures the curriculum so that it attends to issues of human behavior. Neither has had wide acceptance, and the impact has not been great. The author next presents an experimental program of teaching behavioral sciences as a formal subject. The rationale for such a program is threefold: it will (1) facilitate strengthening of the child's ego, (2) provide more comfort in the learning tasks of school, and (3) encourage interest in behavioral sciences. The initial program, essentially a course in general psychology, was taught for 40 minutes a week over two semesters to a fourth grade class. An evaluation of the program showed not only significant scores in achievement, but also positive changes in causal thinking and democratic behavior, and possible effects in other areas. The program is relatively easy to implement, and very flexible in the manner in which it can be presented.

486. **Rustad, K., & Rogers, C. (1975). Promoting psychological growth in a high school class.** *Counselor education and supervision, 14,* 277–285.

This article describes a curriculum and presents research results of a primary prevention model designed to promote the personal growth of high school students. The curriculum intervention was based on an operational translation of cognitive-development theory. Using a practicum-seminar format, 13 students learned and practiced the basic counseling skills of active listening-empathic responding. The three-hour classes were held one evening/week for 12 weeks. Data indicate that significant gains made during the intervention decreased only slightly 1 year later, and the decrease was not statistically significant. The development of role taking is seen as the essential variable in the promotion of personal growth and development. ©APA.

487. **Sprinthall, N.A., & Erikson, V.L. (1974). Learning psychology by doing psychology: Guidance through the curriculum. *Personnel and Guidance Journal, 52,* 396–405.**

Experimental results of a program with the dual goals of teaching psychological content to high school students and promoting individual psychological growth are reported. Evaluation of 23 sophomore girls who elected the program indicates that it is possible to promote positive psychological growth in a regular school class; the integration of content and process in curriculums that promote psychological and intellectual growth can become a new focus for school counselors; and it is possible to link instructional and counseling models to a given theoretical position. The data on the psychological growth of the students support the descriptive stages of growth set forth by cognitive developmental theorists. It is concluded that an integrated set of learning experiences patterned after this model could lead to a primary preventive and developmental education program for all students.

See also: 198, 431, 493, 529, 609, 610, 611, 625, 633, 908, 914, 915, 956, 996.

4. Psychosocial Skills Competence Building

488. Burchard, J.D. (1979). Competitive youth sports and social competence. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 171–196). Hanover, NH: University Press of New England.

This article reviews the relationship between organized competitive sports for children and the development of social competence; the literature on the incidence and the social effects of competitive youth sports; and research that demonstrates sports psychology may provide important data on how a sport and a coach's philosophy about winning can influence the kind of social competence acquired by youth. There appears to be sufficient evidence to show that aggressive, win-at-all-costs coaching tends to produce more aggressive and less prosocial behaviors in youth participants. It is also clear that in some situations, adults prevent children from making changes in games that would make playing more reinforcing and less aversive for many of the participants.

The implications of the sports program for promoting social competence and primary prevention of psychopathology are discussed.

489. Durlak, J.A., Mannarino, A.P. (1977). The social skills development program: Description of a school-based preventive mental health program for high-risk children. *Journal of Clinical Child Psychology, 6*, 48–52.

The Social Skills Development Program––a school-based, prevention-oriented mental health program for high-risk children––is described. The program seeks to develop children's social skills using behavioral or relationship therapeutic strategies in combination with a unique series of small group activities. Techniques to identify and select children at high risk for later serious school maladjustment and the group activities and exercises used in the program are described in detail. This information on the operation of the program is offered for the benefit of other investigators who may wish to incorporate or modify various program procedures for application in other settings.

490. Fisher, R., & Garrison, C. (1977). Transactional analysis and role training in the classroom: A pilot study. *Group Psychotherapy, Psychodrama, & Sociometry, 30*, 142–145.

A pilot study in preventive mental health that involved transactional analysis and role training in the elementary school classroom is described. The aim of the experience was to enhance and expand social relationships by directing students in the study about their own personal makeup and the nature and quality of the interpersonal transactions in which they engaged. Sociometric techniques demonstrated that the group methods used in this study did aid in the improvement and expansion of social relationships. Educators are cautioned that the classroom is not only a place where cognitive abilities are developed but also an environment in which significant social and emotional learning occurs.

491. Hartman, L.M. (1979). The preventive reduction of psychological risk in asymptomatic adolescents. *American Journal of Orthopsychiatry, 49*, 121–135.

To explore the preventive efficacy of training in coping and social skills, 121 high school students were assigned to four risk classifications, assessed by measures of psychological vulnerability and environmental adversity. Within each group, Ss were randomly assigned to a preventive intervention or an assessment-only control condition. Findings suggest that group behavioral training can be a beneficial and economical preventive approach with symptom-free high school students and that training in social skills may benefit those with behavior problems that presage maladjustment. ©APA.

492. **Lynch, D.J., & Kahl, R. (1977). Integration of positive emotional experiences as part of a recreation program.** *Journal of Community Psychology, 5*, 175–179.

An evaluation of a program designed to enhance adjustment skills and prevent development of emotional problems in children by integrating positive emotional experiences into a recreation program is described. Participants were children, aged 9 to 12, in a summer recreation program administered by a neighborhood settlement house. One group was given small group experiences to enhance self-acceptance and acceptance of others, while the other group participated in the usual recreation activities. Special experience participants demonstrated a significantly greater decrease on self-reported anxiety and impulsivity measures. No significant differences occurred between the groups on measures of self-concept and ideal self, nor on social adjustment ratings made by the staff. Six months after the program ended, there were no differences between the groups on either the anxiety and impulsivity measures or the self-concept and ideal self measures. However, teachers' ratings at the followup favored the special experience group with respect to their ability to get along with others, exert self-control, and assume responsibility for work.

493. **Schulman, J.L., Ford, R.C., Busk, P.L., & Kasper, J.C. (1973). Mental health in the schools.** ***Elementary School Journal, 74*, 48–56.**

In this article, a teacher-taught primary prevention program requiring minimum preparation by the teacher is described. The program provides a structured situation in which teachers explore varying aspects of personality and interpersonal interaction with their pupils. Units include material on friendship, getting along with adults, and the universality of feelings such as shyness, jealousy, and hostility. This program promotes developmental goals and requires few resources from an overburdened mental-health field.

494. **Vogelsong, E.L., Most, R.K., & Yenchko, A. (1979). Relationship enhancement training for pre-adolescents in public schools.** ***Journal of Clinical Child Psychology, 8*, 97–100.**

The utility of enhancement of development programs and the educational model of therapy intervention for primary prevention programs in the public schools is examined. An example of a program to teach relationship enhancement at the fifth grade level is described. To assess the effectiveness of the program, participating and control subjects were compared on behavioral tests of empathic acceptance. Results indicated that the participating children showed significantly greater gains in empathic responding than the control group. Implications for primary prevention programs are noted.

See also: 321, 333, 384, 428, 429, 483.

C. Competence Building with Adults

495. Baruch, G.K., & Barnett, R.C. (1980). On the well-being of adult women. In L.A. Bond & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competence and coping during adulthood* (pp. 240–257). Hanover, NH: University Press of New England.

Factors that facilitate psychological well-being in adult women are examined. Emphasis is placed on the social changes in occupational competence and economic independence critical for women's successful adaptation and the varied effects of multiple role involvements among married women with young children who differ in employment status. The findings indicate that sources of self-esteem and satisfaction available to married women with young children are highly dependent upon husbands' approval. Employed women are also sensitive to husband's attitudes, but less so, while their commitment to work and satisfaction with current job also contribute heavily to well-being. Involvement in multiple roles is not necessarily seen as resulting in debilitating conflict, strain, and dissatisfaction, and may even protect against such stress as that associated with the empty nest syndrome and aging. These results support the value of preparing young girls to develop and exercise occupational competence.

496. Danish, S.J., Galambas, L., & Laguatra, I. (1983). Life development intervention: Skill training for personal competence. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research, and practice* (pp. 49–65). New York: Pergamon Press.

Skills training as a means for developing personal competence, while methodologically grounded in learning theory, lacks a conceptual base. The authors argue for a lifespan development perspective to guide not only specific skills training, but the development of values and behaviors consistent with a philosophy of life development that promotes life planning, goal-setting, and the development of feelings of self-efficacy. Assessment of interpersonal skills, methods for training, and the values guiding life development intervention are discussed.

497. **Gatz, M. (1982). Enhancement of individual and community competence: The older adult as community worker.** ***American Journal of Community Psychology, 10,*** **291–303.**

The author evaluated the first year of a 2-year primary prevention program designed to enhance individual and community competence in older adult community workers and in community residents with whom they worked. Twenty-two community workers (mean age 63 years) and 97 community residents participated in the study; 30 residents constituted a posttest-only control group. Workers attended 2-day workshops to learn about interviewing, problem solving, and community resources at the beginning of the program. All Ss completed preprogram and postprogram self-report measures of competence. Changes noted included increased knowledge of community services among all participants, as well as increased number of community information channels and increased life satisfaction for the workers. Residents, particularly black residents, became more internal, and their increased sense of personal control was related to their increased knowledge of services. Thus, the helper-therapy principle was supported for these older adult, mostly female, community workers, and their helping role had an overall empowering effect. ©APA.

498. **Paster, V.S. (1977). Organizing primary prevention programs with disadvantaged community groups. In D.C. Klein, & S.E. Goldston (Eds.),** ***Primary prevention: An idea whose time has come*** **(pp. 85–89). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

A primary prevention-oriented social advocacy/stressor amelioration program sponsored by a Northwest Manhattan community mental health center (CMHC) is outlined. The population served is 50 percent black, 30 percent white, and 20 percent Hispanic. Leadership training, provision of information, and development of personal competence through experience with self and community advocacy provided the means for emotional stressor amelioration. Police and the law, housing problems, and consumer concerns are a few of the areas in which training and/or advocacy were undertaken. Problems and considerations in the development, implementation, and maintenance of such a program are discussed. Positive preventive effects of the program included increased knowledge and utilization of CMHC services and greater coping abilitites and self-esteem, as well as less apathy, isolation, and powerlessness among actively involved participants.

See also: 422, 434, 459, 586, 599, 651, 652, 656, 719, 784, 858, 872, 877, 895, 1004.

VI. Parent Training

Parents, by virtue of their very important role in the social and cognitive development of children, have been the focus of a number of primary preventive interventions. The premise behind these interventions is that training parents in proper childrearing methods and/or educating them about certain facets of infant, child, and adolescent development will serve to prevent certain psychological problems that might otherwise occur in their offspring. Articles have been divided into two sections. The first contains general statements, conceptualizations, and proposed strategies concerning parent training as a method of primary prevention. The second includes descriptions of actual programs involving the education of parents.

A. Strategies, Conceptual, and Position Papers

499. **Balter, L. (1976). Psychological consultation for preschool parent groups: An educational psychological intervention to promote mental health. *Children Today*, 5, 19–22.**

The benefits of psychological consultation for preschool parent groups are analyzed. It is believed that a discussion group held under the direction of a psychological consultant can provide parents of preschoolers with an opportunity to share their experiences with others and increase their repertoire of childrearing techniques. Such a parent discussion group could be useful in cases of deviant behavior, as an indirect mode of treatment in interviews with concerned parents, and as a preventive procedure. It is thought that the nursery school setting is particularly well suited for group discussion in matters of child development and childrearing. It is believed desirable to involve fathers as well as mothers in these groups.

500. **Brown, J.A. (1981). Parent education groups for Mexican-Americans. *Social Work in Education*, 3, 22–31.**

The failure of many American schools to provide adequate education for low-income Mexican-Americans is addressed, and the role of school social workers in helping to correct this neglect is emphasized. It is contended that education is one of the primary tools for helping minority youths gain social mobility and in preventing the growth of subcultures of poverty. Social workers are urged to take preventive action with groups of parents to dispel the negative cycle that envelopes many minority children in the educational system as a result of its failure to recognize their special needs. Such groups are seen as having goals beyond helping people to become better parents, and as aiding them in developing effective interactions with their children and with the school system. They use a social goals orientation that aims at reestablishing some kind of social reform at the neighborhood level. The social worker is seen as assuming the roles of educator and change agent.

501. **Brim, Jr., O.J. (1961). Methods of educating parents and their evaluation. In G. Caplan (Ed.), *Prevention of mental disorders in children*. New York: Basic Books.**

The choice of parent training methods is said to proceed from three basic groups of assumptions, both ethical and scientific. These include assumptions regarding the goals of the procedure, the effects of parents in contributing to mental disorders of their children, and the presumed conscious and unconscious determinants of parental behavior. Three major educational methods including mass media, counseling, and group discussion are described. Evaluation of the effectiveness of parent training programs are said to be inadequate in most cases due to methodological problems in program designs. The results of nearly two dozen studies suggest that the effectiveness of these programs remains unresolved.

502. **Cook, P.S. (1970). Antenatal education for parenthood, an aspect of preventive psychiatry. *Child and Family, 9*, 209-220.**

"The purpose of this paper is to suggest an outline of some of the essentials in knowledge and understanding which, if they could be acquired by parents in the early stages of parenthood, could be expected to assist them in promoting cooperative family relationships and the healthy emotional development of their children." There is a need for parent education, and the antenatal period is a useful time to conduct such education in the service of preventive psychiatry. A content for such education is proposed, including (1) an understanding of normal development in children, (2) the development of health-promoting attitudes toward the child, (3) preparing the parents for the establishment of healthy parent-child relationships, and (4) promoting healthy interaction between parents. The specifics of each of these focus areas are discussed.

503. **DeRosis, H.A. (1970). Parenting: Is education necessary? *Journal of School Health, 40*, 321–323.**

This brief essay makes the statement that parenting is the most important job in the world and that the quality of parenting a child receives has a profound effect on his or her mental well-being. In order to enhance parents' ability to raise their children, education for parenting should be included in the school curriculum.

504. **Hawkins, R.P. (1971). Universal parenthood training: A laboratory approach to teaching child-rearing skills to every parent. *Educational Technology, 11*, 28–31.**

Present childrearing practices are discussed and a preventive program in childrearing that would be required universally is proposed. Three areas of course content would concern what a child is like, what behavior the parent should develop in the child, and the ways in which these behaviors can be developed. Training in parenthood is seen as a positive contribution to society and is therefore worthy of being included in school curriculum.

505. **Hawkins, R.P. (1972). Stimulus/response: It's time we taught the young how to be good parents (and don't you wish we'd started a long time ago?). *Psychology Today, 6*, 28, 30, 36, 38–40.**

A mandatory parent training program in the public schools is discussed. The home environment has the most profound effect on the growing child and has, of late, failed to provide for the behaviors, perceptions, values, skills, and attitudes that must be learned. Three different ways to design a preventive program oriented toward home are enumerated: (1) helping parents by giving all children supplementary learning experiences; (2) a program like the Israeli kibbutz with its problem-preventive childrearing system that largely shoulders the instructional responsibility of parents; and (3) leaving the responsibility of childrearing to the parents while teaching the parents skills necessary to do the job well. At the high school level, both boys and girls would learn how to teach children but not what to teach them. Courses in basic behavioral techniques and methods of childrearing would be supplemented by practical experience with nursery school children.

506. **Jones, M.A., Magura, S., & Shyne, A.W. (1981). Effective practice with families in protective and preventive services: What works? *Child Welfare, 60*, 67–80.**

Ideas, methods, and techniques that have been helpful in dealing with families receiving preventive and protective services are discussed in terms of three parameters. The first parameter is duration of service, and it appears that the time required to achieve reasonable goals depends on the number and severity of client problems, the degree of client motivation, and the content and structuring of the service. While some families may never be able to cope with their child care responsibilities, others can make considerable gains within a few months. The content of services is the second parameter, and it is considered that a comprehensive program of services is more effective for families than any single service. The third parameter is contracting with clients, which addresses several serious and ubiquitous problems. However, research suggests that contracting will not work for all clients in all situations.

507. **Levenson, P., Atkinson, B., Hale, J., & Hollier, M. (1978). Adolescent parent education: A maturational model. *Child Psychiatry and Human Development*, *9*, 104–118.**

Health care, educational, and social programs are frequently required to assist increasing numbers of adolescent mothers to meet their own needs and those of their babies. This paper presents a maturational rationale for development of a comprehensive parent education program. Some pertinent aspects of adolescent psychological development are first presented to provide a perspective for understanding the models illustrating the teenage mother's responses to her child. Barriers are then delineated that commonly restrict the young mother from attaining the mature relationship with her baby presented in a maturational model. Specific recommendations are offered in the areas of program development, content, and structure. (Author abstract)

508. **Ratcliffe, T.A. (1968). Preventive mental health. *Public Health*, *82*, 165–169.**

This article focuses on the positive mental health consequences of satisfactory childrearing methods. The areas where professional influence impinges on childrearing are mentioned, including contact with parents, contact with children, and in the training of students. The tendency of psychiatrists to offer advice too readily to parents is noted, as is the tendency to be too "laissez faire" in understanding the authority aspect of relationships with children. With respect to the area of training, the author argues for a balance between theory and practical experience, as well as a balance between the study of "normal" and "abnormal" behavior. Finally, emphasis is placed on the importance of self-knowledge on the part of the professional.

509. **White, B.L. (1980). Primary prevention: Beginning at the beginning.** ***Personnel and Guidance Journal, 58,*** **338–343.**

The growth and development of infants and children is examined from the perspective of parenting and primary prevention. Evidence on early childhood development is presented in support of the claim that educators and mental health specialists ignore these findings in their intervention approaches. The family is seen as the first educational delivery system for the child, and concrete suggestions are made to aid educators and mental health workers in their role. This educational approach to parenting is favored over traditional social service models, and concentrates on four basic foundations of basic learning: language development, curiosity, social development, and cognitive intelligence.

510. **Wimberger, H.C. (1979). Parent education and training around the first child. In I.N. Berlin, & L.A. Stone (Eds.),** ***Basic handbook of child psychiatry, Vol. 4: Prevention and current issues*** **(pp. 168–172). New York: Basic Books.**

The author argues that parent education and training are among the most viable of preventive interventions. This area can be divided into three types of involvement: (1) physical contact in different situations such as feeding and soothing; (2) stimulation and facilitation of cognitive development; and (3) the establishment of flexible and suitable role patterns with the necessary communication skills. Parents' effectiveness is co–determined by the strength of their social support system, their emotional state, and constitutional temperamental factors. The author goes on to describe some periods in which specific parent training interventions can be made. These periods include pregnancy, the neonatal stage, and early infancy. During pregnancy it may be important to pay attention to the new developments and changes in the parents' relationship as they anticipate the birth of their child. During the neonatal stage, increased interaction with mother and infant may be important in fostering their relationship. The role of the parent in the social and cognitive development of the child is briefly discussed.

511. **Woodmansey, A.C. (1979). First things first: A blueprint for mental health.** ***Public Health, London, 93,*** **131–139.**

The author states that the problem of mental illness can be solved only by prevention, which must depend on enabling children to grow up with positive relationships with parent figures. Immense though the task appears, its eventual achievement is not beyond the potentially available resources. A scheme for their effective use is outlined, in which key workers receive counseling support from experienced therapists, so that they can, in turn, help parents with difficulties in relating to their children who, as a result, should eventually relate healthily with their own children, and so on. If the hypothesis underlying these proposals is correct, no other solution will do, and research not directed to testing it will be beside the point. (Author abstract modified)

See also: 62, 65, 105, 120, 136, 196, 229, 251, 275, 276, 290, 356, 368, 380, 384, 386, 415, 417, 427, 452, 455, 465, 519, 543, 546, 547, 548, 569, 577, 579, 581, 594, 595, 600, 658, 680, 737, 803, 835, 861, 897, 902, 912, 994, 1007.

B. Descriptions of Programs

512. **Atkeson, P., & Guttentag, M. (1975). A parent discussion group in a nursery school. *Social Casework, 56*, 515–520.**

A parent discussion group in a nursery school is described. It offers early preventive intervention for parents and teachers of young children. The school involved is a private nursery school for approximately 150 children, aged 2.5 to 7 years. The group fosters parent/teacher sharing of concerns, questions, and experiences in their relationships with their children. Topics discussed include peer and sibling relationships, emotional development, discipline, anxieties, family problems, concerns for working mothers and single parents, and sex-role identification. It is concluded that a parent discussion group on child development is an inexpensive, uncomplicated social work service that can be usefully offered to parents in many types of school settings.

513. **Beebe, E.R. (1978). Expectant parent classes: A case study. *Family Coordinator, 27*, 55–58.**

Mental health problems among young children were found to result from poor parenting, a high neonatal death rate in the country, and a low level of medical education in Bedford County, Pennsylvania. These problems provided the impetus for developing a primary prevention program called the Expectant Parent Program. The first part of this article summarizes the development, content, staff, and funding of the Expectant Parent Program. The second half reviews some of the results of the evaluation by parents involved in the first year of the program. The article attempts to provide a model for education to increase the effectiveness of parenting, and describes a program developed in a rural county that may be duplicated in areas with similar mental health and medical problems. ©APA.

514. **Belsky, J., & Benn, J. (1982). Beyond bonding: A family-centered approach to enhancing early parent-infant relation.** In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development*. Hanover, NH: University Press of New England.

In this chapter, intervention programs that focus on mother-infant interaction and bonding are reviewed. The authors state the opinion that early contact between mothers and infants is important, not simply because of skin-to-skin contact, but because of the process of learning to interact with one another in many ways: touch, sight, words, etc. Caution is urged in judging the effectiveness of these interventions because of faulty methodology and lack of long-term followup. However, it is suggested that the basic premises underlining these interventions are sound. The authors describe their intervention program: it expands the unit of intervention from the mother-infant or father-infant dyad to the family. The Brazelton Neonatal Behavioral Assessment Scale is used as a tool for educating parents about their infant and in fostering husband-wife interaction with regard to their baby. The project is in its infancy, so no results are reported.

515. **Berlin, I.N., & Berlin, R. (1973). Parents' role in education as primary prevention.** *American Journal of Orthopsychiatry, 43*, 221-222.

The role of parents in education as primary prevention was studied. Preliminary data from several pilot projects reveal that some parents at all socioeconomic levels have little to do with effective learning experiences of their small children. Efforts to help parents learn to teach their children effectively alter parental attitudes towards learning and the child's attitude toward, and capacity for, learning. Parents' regular involvement in preschool and school programs enhances parental capacity to collaborate with educators and developmental specialists and also has a major impact on what is taught and how it is taught in the classroom. Mental health implications for parents and children are discussed.

516. **Berlin, R., & Berlin, I.N. (1975). Parents' advocate role in education as primary prevention.** In I.N. Berlin (Ed.), *Advocacy for child mental health* (pp. 145-157). NY: Brunner/Mazel.

The failure of remedial and enrichment programs for school-age children is explained in terms of deficiencies and early home experience and the detachment of parents from their children's education. Programs in San Francisco and Seattle that used parents as teacher helpers and advocates for their children's education are discussed. A model elementary school program that attempts to make full use of parent help to increase the school achievement of children is presented. Parent involvement on a nationwide basis, as participant advocates in their child's learning, is proposed as a way to improve the achievements of the child and the mental health of children, parents, and teachers.

517. **Brown, S.L., & Reid, H. (1976). The warm-line—a primary preventive service for parents of young children. In H.J. Parad, H.L.P. Resnik, & L.G. Parad (Eds.), *Emergency and disaster management* (pp. 407-416). Bowie, MD: Charles Press.**

The "Warm-Line" is a telephone consultation service that provides suggestions, alternatives, and information about child development and interested reassurance to parents with worries about parenting children up to 5 years of age. It is suggested that pediatricians and physicians are insufficiently prepared to meet the mental health needs of families with young children. Trained mental health professionals who allow parents to ventilate their feelings, who provide factual information about child development, and who make direct suggestions about how particular problems might be resolved seem to meet the primary prevention challenge very well. For about half the people who call the Warm-Line, telephone discussion seems to be adequate. For the other half, more specific clinical interventions can be arranged. It is noted that resistance to using mental health facilities needs to be circumvented, and so the Warm-Line emphasizes that its service is for *normal* parents with *normal* worries about *normal* children. To aid parents in deciding if they should contact the Warm-Line, a checklist has been created. In a followup of 26 families, 80 percent reported positive feelings about the brief clinical intervention.

518. **Clegg, J. (1981). STEP—A big prevention program on a small budget. *Advance, 31*, 7-9.**

The implementation of the program, Systematic Training for Effective Parenting (STEP), is described. STEP is based on common sense childrearing principles. It utilizes inexpensive teaching materials and is designed so that parents who take the course can be trained to lead future groups. Since its introduction, the number of STEP groups has increased, and only volunteer leaders have been used. Also, two new components were added for high school students: units on substance abuse and sex education.

519. **Cyr, F.E., & Wattenberg, S.H. (1957). Social work in a preventive program of maternal and child health. *Social Work, 2,* 32–39.**

This article describes how casework services in an interdisciplinary maternal-child-health setting can provide preventive mental health services. The authors provide a guideline for the teamwork approach to provision of comprehensive prenatal and post-natal care. The specific developmental issues of pregnancy and emerging parenthood are stressed as the framework for the provision of mental health promotion services. The social worker's role in this service is discussed, showing how traditional skills of providing a supportive relationship, ego support, clarification, environmental modification, and anticipatory guidance, in the context of health, rather than pathology, promote mental health and positive coping during a developmental crisis. Specific case illustrations are offered to indicate how the team worked with several of the clients.

520. **D'Augelli, J.F., & Weener, J.M. (1978). Training parents as mental health agents. *Community Mental Health Journal, 14,* 14–25.**

The utilization of parents as mental health agents for their children is a service delivery strategy likely to have major impact on enhancement of normal families. Using an educational enhancement model, a parenting relationship training program was designed and implemented with 58 parents having at least one child in the fourth, fifth, or sixth grade. Parents were introduced to the concepts and behavior skills of empathic responding, giving "I" messages, anticipatory structuring, limit setting, and modeling for preferred behaviors. These response skills were offered as potentially effective alternatives to the more common parental responses such as shaming, moralizing, ridiculing, denying or ignoring feelings, and arbitrarily commanding. Initial evaluation of specific short-term effects and differences between mothers and fathers are discussed. Implications for further program development and evaluation are noted.

521. **DeRosis, H.A. (1969). A primary prevention program with parent groups in public schools. *Journal of School Health, 39,* 102–109.**

In this article, the author, a psychoanalytically oriented psychiatrist, describes a program developed to work with parents in New York City schools. The goals of the program were to effect positive changes in parents' attitudes and available options in childrearing so as to have a preventive effect on their children. The program consisted of 1-hour-per-week group sessions with parents of both problem and nonproblem children. While no formal evaluation was undertaken, it was suggested that the group sessions had primary, secondary, and tertiary preventive effects. ©APA.

522. **DeRosis, H.A. (1970). Parent group discussions: A preventive mental health technique.** ***The Family Coordinator, 19,*** **329–334.**

Techniques used in a program of group discussion sessions for parents of problem and nonproblem children in two inner-city schools are described. One-hour sessions are held once a week and parents are encouraged to air their concerns about their children. With the consulting psychiatrist or school guidance counselor acting as group coordinator, the parents in the group help one another identify the problems, come up with alternative ways of handling situations, and encourage putting new ideas into practice. The program's goals are to (1) change parental attitudes and practices in order to prevent mental problems in their children, (2) train guidance counselors to lead parent groups in their schools, and (3) demonstrate a new role for psychiatrists as educators and group discussion leaders.

523. **Dubanoski, R.A., & Tanabe, G. (1980). Parent education: A classroom program on social learning principles.** ***Family Relations, 29,*** **15–20.**

A 9-week parent education program using a classroom format was found to be effective in teaching parents the concepts and application of social learning theory to child behavioral development. The results are discussed in terms of efficiency, prevention of childhood behavior problems, program content, and actual changes in parent behavior. The success of the program was attributed to the fact that it emphasized development of desirable behavior patterns and prevention of undesirable ones, rather than the actual treatment of behavior problems.

524. **Glidewell, J.C., Gildea, M.C.L., & Kaufman, M.K. (1973). The preventive and therapeutic effects of two school mental health programs.** ***American Journal of Community Psychology, 1,*** **295–329.**

The preventive and therapeutic effects of two school mental health programs were studied. In 30 classrooms randomly assigned to experimental conditions, effects of mothers' reports of behavior symptoms were compared for (1) a parent education program; (2) an in-school program of consultation, counseling, training, and referral; and (3) control classrooms. A sample of 426 families was followed for 30 months from the child's entry into third grade. A simple unweighted count of the number of symptoms reported in a home interview had adequate validity, good reliability, low reactivity, and intrinsic significance. Both programs had significant preventive and therapeutic effects on boys but not on girls. Effects were immediate in the upper-middle-class families, delayed in the lower-class families. (Author abstract) ©Plenum Publishing Corp.

525. **Gordon, T. (1977). Parent effectiveness training: A preventive program and its delivery system. In G.W. Albee, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 1: The issues* (pp. 175-186). Hanover, NH: University Press of New England.**

Principles for parent-effectiveness training (PET) are enumerated, along with the goals of trying to reach a large number of parents in many communities and maximizing the program's acceptance by parents. The PET instructors, what parents learn from PET, and some limitations of PET are discussed. The author proposes that, through the program, parents acquire knowledge and skills and that additional learning occurs when the parents apply their knowledge and skills to real problems in the home. The author suggests using primary prevention because it focuses on parents--those people who have the earliest and/or greatest influence on a child's emotional/physical health and social/intellectual development.

526. **Grando, R., & Ginsberg, B.G. (1976). Communication in the father-son relationship: The parent-adolescent relationship development program. *Family Coordinator, 25,* 465-473.**

The Parent-Adolescent Relationship Development (PARD) program, which teaches communication skills to fathers and their adolescent sons, is described. The author emphasizes the program's preventive nature; i.e., the skills can be used on a continuous basis to forestall development of difficult problems. Basic skills taught include openness and empathy, along with democratic techniques and avoidance of potentially negative techniques. Information obtained from its trial use in one area of Pennsylvania suggests that, besides improving communication and parent-child relationships, the program meets individual and family developmental needs and facilitates the consequent adjustments in the relationship. (Author abstract modified)

527. **Helfer, R.E. (1979). Childhood comes first: A crash course in childhood for adults. *Child Abuse and Neglect, 3,* 897-898.**

An approach to prevention of and treatment of parenting deficiencies is presented to adults who were unable to learn basic interpersonal skills when they were children. Described as a crash course in childhood, the content and skills learning program is conceived as a primer or prerequisite for parenting courses. Content of the course includes interacting with one's environment, with one's self, and with others. The author emphasizes sexual interaction, pregnancy, and parent/baby bonding or attachment.

528. **Huber, H., & Lynch, F. (1978). Teaching behavioral skills to parents: A preventive role for mental health. *Children Today*, 7, 8–10.**

Emphasis is currently shifting from a treatment orientation to a preventive orientation in the delivery of services to children and their families. While most child problems brought to clinics are learned behaviors, and can thus be unlearned, parents often lack the necessary knowledge or skills to deal effectively with their children to prevent problems from arising. The authors propose that parent training groups be created as a forum for teaching relevant skills to parents, and they describe a program for parents that they created. The program was a highly structured and focused program using a behavioral approach. Parents were encouraged to develop behavioral change projects with their children and to discuss their effectiveness in the parent groups. Parent reports of the success of these projects was positive.

529. **Kairys, J.W., Conant, B.E., & Kairys, S.W. (1981). Great expectations: Preventive health concepts in childbearing and parenting for college students. *Journal of the American College Health Association*, 29, 299–301.**

A program to introduce preventive health concepts in childbearing and parenting to college students was introduced on a university campus in light of recent findings that health status prior to conception is a major factor in successful pregnancy and parenting. The program focuses on five major areas of lifestyle that have a significant impact on health: (1) self-responsibility for personal health (including intelligent use of alcohol and cigarettes); (2) nutrition; (3) physical fitness; (4) stress management and the learning of coping skills to manage the emotional aspects of pregnancy; and (5) environmental awareness and knowledge of external risks to the developing fetus. The program is designed to have short-term influence on knowledge about family life and long-term impact on improving behavior related to personal health, childbearing, and parenting decisions and actions.

530. Kantor, M.B., Gildea, M.C.L., & Glidewell, J.C. (1969). Preventive and therapeutic effects of maternal attitude change in the school setting. *American Journal of Public Health*, *59*, 490–502.

This article discusses the results of a research project that investigated how a school mental health program affected maternal attitudes and the general adjustment of children. The project was based on the proposition that specific maternal attitudes are related to child adjustment and that a school mental health program that changes maternal attitudes will result in changes in child adjustment. Various maternal attitudes were targeted, including uncertainty about childrearing techniques or standards and mothers' feelings of responsibility for influencing behavior problems of their children. The final sample included 425 white mothers of third-grade pupils, from whom information on attitudes and child adjustment was gathered. Findings showed that some attitudes of mothers were related to select indices of the general adjustment of children, including degree of maternal uncertainty about childrearing. In addition, changes in maternal attitudes over time had produced changes in child behavior, but only for the lower social class. Other effects of the school mental health program are also noted.

531. LeCroy, C.W., Koeplin-LeCroy, M.T., & Long, J. (1982). Preventive intervention through parent-training programs. *Social Work in Education*, *4*, 53–62.

The effectiveness of a preventive program of parent education that taught parents techniques to eliminate undesirable behavior in children and positively reinforce prosocial responses was evaluated using 11 families, 4 of whom were Spanish-speaking. The program included measures of effectiveness and made use of lectures, group discussion, reading assignments, role-playing, and consultation. The parents showed high levels of attendance and productivity as well as large gains in comprehension as assessed by pretest and posttest measures. This program was found to be useful with parents differing in educational level, socioeconomic status, ethnic background, and type of problem. Class members benefited from the group experience by becoming a cohesive, mutually supportive unit. This kind of class, being cost effective and focusing on prevention, may provide important protection for parents, children, and society.

532. **Minde, K.K., Shosenberg, N.E., & Marton, P.L. (1982). The effects of self-help groups in a premature nursery on maternal autonomy and caretaking style one year later. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 6: Facilitating infant and early childhood development* (pp. 240–258). Hanover, NH: University Press of New England.**

A primary prevention program that involved parents of premature infants in self-help groups in a hospital setting is presented, along with data from a 1-year followup study. Twenty-eight experimental and 29 control families took part. The experimental group met in small groups of four to five families with a "veteran" mother, or mother and father, and a professional staff member at the hospital. The groups met from 7 to 12 weeks to share feelings, give one another support, learn about the developmental and medical needs of their infants, get assistance with concrete tasks (such as finding a babysitter or better housing), and learn about community resources. Early data suggested that experimental parents visited their infants more than controls and touched, talked to, and looked at their infants more. In a followup study 1 year later, experimental mothers allowed their children more autonomy, stimulated them more socially, and had expectations of them more consistent with their age than did control mothers. The experimental mothers were also presented as more autonomous, self-reliant, and confident in the role of mother and in other aspects of their lives.

533. **Mitchell, D.C., & Scherman, A. (1977). Primary prevention as an alternative mode to psychological intervention with children. The other side of the mountain. *Journal of Clinical Child Psychology, 6*, 30–31.**

The use of primary prevention as an alternative mode of psychological intervention is proposed, and some of the negative aspects of traditional child psychotherapy are discussed. Following a theoretical presentation of primary prevention, an applied community-based program that is being implemented in rural Oklahoma by a public health guidance center in cooperation with the local schools is presented to serve as a model for implementing prevention. In the existing program parents and prospective parents are recruited for parent training via high school classes, prenatal classes, local physicians, mass media advertisements, and day care centers. It is concluded that, through the channels of professional service, consultation, curriculum, and peer facilitation, a comprehensive, primary prevention program can be provided for the elementary school child. (Author abstract modified)

534. **Morris, A.G. (1976). The use of the well-baby clinic to promote early intellectual development via parent education. *American Journal of Public Health, 66*, 73–74.**

This paper describes an inner-city Parent Education Program (PEP) as a component of a pediatric clinic. The program included a series of structured lessons designed to show parents how to use play activities to teach age-appropriate concepts to young children of 20–39 months. The sample consisted of black and Puerto Rican families. I.Q. scores of children whose parents participated showed "modest gains" maintained 6 months after the program. Parent response to the program was positive, and recommendations for a lengthier program and the development of programs for older children were made. Because the medical care facility is often the primary institutional contact for preschool children from poor families, the program described in this paper is seen as serving "as an ecologically viable base for a cognitively oriented intervention program by providing a needed service for the captive audience of waiting parents."

535. **Muro, J.J., Hudgins, A.L., Shroudt, J.T., Kaiser, H.E., & Sillis, P.C. (1977). HRD technology and parent training groups. *Elementary School Guidance and Counseling, 12*, 59–61.**

The effectiveness of a skills training parent education program based on a Human Resource Development (HRD) model for primary prevention was assessed in single parents who attended eight 60-minute sessions that concentrated on one social skill using a tell/show/do format. Single parents were selected due to their perceived high-risk status for ineffective parenting. Results showed that significant gains in responding skills were made in a relatively short time. Findings imply that school counselors and psychologists can effectively and meaningfully help parents to improve their communication skills and thus have a helpful impact on parent-child relations. Utilizing the HRD model, these personnel can intervene before a crisis occurs.

536. **Runyan, A., & Fullerton, S. (1981). Foster care provider training: A preventive program. *Children and Youth Services Review, 3*, 127–141.**

A preventive program for training in parenting for use by foster care providers, based on a competence rather than a deficit model of prevention, is described. Foster children and foster parents are both vulnerable populations. Although long-range outcome studies of foster care are not conclusive, foster children are certainly at risk for developing long-range problems if they do not satisfactorily deal with the immediate problems in their own family situations and in foster care. Foster parents are also at risk, in that, if their parenting skills are not adequate for the great demands of foster care, their self-esteem and confidence as parents may suffer. The training program was designed to reduce these risks. Evaluative data suggest that parental attitudes improved among participants, problem behavior of foster children decreased, and parent/agency relationships improved. A high level of satisfaction with the program was expressed by participants. (Author abstract modified)

537. **Sifeneos, P.E. (1959). Preventive psychiatric work with mothers. *Mental Hygiene, 43*, 230-236.**

This paper describes preventive psychiatric work with mothers who had a disturbed relationship with one of their children. An intervention program with the mothers is described. Initial interviews with mother and child yielded one of three strategies. In particularly serious cases, referral for psychiatric treatment was made or treatment was provided at the clinic. In 94 percent of the 50 cases, however, the disturbance was seen as mild, and preventive steps were taken. Usually a few interviews with the mother yielded an improved relationship with the child. Case examples are given, and it is suggested that such early detection is useful in preventing serious maladaptation at a later time.

538. **Signell, K.A. (1973). Parent-child communication course. *exChange, 1*, 50-53.**

A parent-child communication course designed to give parents a main alternative to the authoritarian-permissive polarity of childrearing is described. It is given to parents by the local community mental health program and is a model of primary prevention; the impetus for this program was concern about the breakdown in family communications, which contributes to child abuse, juvenile delinquency, and emotional problems in young children. Findings indicate that the parent-child communication format can be adapted for teaching the communication process to various groups in the community.

539. **Signell, K.A. (1976). On a shoestring: a consumer-based source of personpower for mental health education. *Community Mental Health Journal, 12*, 342-354.**

A consumer-based primary prevention program to strengthen the family unit was developed by mental health professionals who shared skills with selected parents. The resulting parent-child communication course focuses on instructive sessions on learning communication skills through active role-playing. Strategies are examined that shifted the role of the professional toward a colleague relationship with nonprofessionals and resulted in a network of nonprofessional personpower. Informal observations and questionnaires indicated that using parents as role models for other parents was an effective and economical teaching method that had an impact on parents and nonprofessional instructors. Practical guidelines are offered for the implementation of similar programs by community mental health centers, family service agencies, or adult education programs. (Author abstract modified) ©Human Sciences Press.

540. **Swift, C. (1980). In Philadelphia prevention is child's play—with parents.** ***Journal of Prevention, 1,*** **134-135.**

The Child and Parent Demonstration and Resource Center in Philadelphia, which targets preschool children and their parents for prevention interventions, is described. Part of the community mental health center of the Pennsylvania Hospital directly served 150 families last year. The center's uniqueness stems from: (1) the fact that parents actively participate in the program with their children, (2) the functionality and charm of the physical play spaces created, and (3) the philosophy that all children are at risk. The formal program consists of a series of play and group experiences, graded by child's age, coupled with staff consultations for each participating family. Aims include positive development and the prevention of emotional stress in children, increased self-esteem and greater knowledge of child development for parents, and improved parent-child relationships. Evaluation of parent satisfaction showed that 60 percent found that the program exceeded their expectations while only 4 percent were disappointed. Student training is also an important feature of the center's extensive outreach program.

541. **Walsh, J.A. (1977). Dr. Seuss meets Dr. Freud: Primary prevention in the community library.** ***American Journal of Public Health, 67,*** **561-562.**

A parent education program, run in conjunction with library story hours for preschoolers, is described. The program consisted of five or six 45-minute sessions designed toward the primary prevention of emotional distress among parents and children. Topics discussed included discipline and punishment, sibling rivalry, behavior modification techniques, temper tantrums, losses, sex education, and childhood illnesses. Small group discussions and exercises were used to support the theory on parent-child needs. An evaluation of the program by the parents indicated an increased understanding of parenting roles.

542. **Yahraes, H. (1977). *Teaching mothers mothering*. (DHEW Pub. No. (ADM) 77-52). Washington, DC: U.S. Government Printing Office.**

Two preventive child-mental-health projects designed to enhance parenting skills of high-risk families, undertaken by Ira Gordon and his colleagues at the University of Florida, are described. In the first project, designed to examine the effectiveness of a home-centered parent education technique for the enhancement of the cognitive, affective, and personality development of mother and child, results of 6-year followup testing indicate that, in general, experimental children show slightly higher IQs and experience fewer educational problems than controls. In addition, experimental mothers are more involved in and attentive to their children's development and learning, are more engaged in self-enhancement, are more achievement oriented and upwardly mobile, and are more aware of their children's individuality. In a second project, it was found that: educational enhancement activities are effective both when directed at the mother and when directed at the child; families are equally accepting of professional and paraprofessional workers; and professionals are more effective working with mothers of girls than paraprofessionals, while paraprofessionals are more effective working with boys than professionals. A parental school-involvement program is described, and parenting practices conducive to child mental health are briefly discussed.

VII. Child Abuse Prevention

Child abuse is a problem that, in and of itself, calls for efforts toward its prevention. In addition, it is likely that abused children form a group who are at higher risk for developing psychological disorders later in life than nonabused children. The focus of most efforts at child abuse prevention involve the use of a parent training/education model. Articles concerning child abuse prevention can be seen from a primary prevention of psychopathology perspective as a hybrid of parent training interventions and early intervention with an at-risk population.

Articles are divided into three sections. The first includes those articles that discuss strategies, involve conceptualizations, or provide reviews related to child abuse preventive interventions. In the second section are papers that discuss screening efforts or preventive interventions with children considered at risk for abuse. Descriptions of preventive interventions with actual or potential victims of child abuse are listed in the final section.

A. Strategies, Conceptual, and Position Papers

543. Alvy, K.T. (1975). Preventing child abuse. *American Psychologist, 30*, 921–928.

The author distinguishes between two approaches for analyzing the problem of child abuse. The comprehensive approach defines child abuse as being collective and institutional as well as individual in nature. It deals with cultural policies and attitudes that are abusive to children as well as with individual cases of abuse. To prevent abuse at this level would require major social changes. The narrow approach focuses on individual child abuse, especially physical abuse. Because of the importance of secondary prevention in this area, primary prevention programs get little of the available funds. Several existing programs have the potential for primary prevention. The Education for Parenthood program represents an essentially educational approach for future parents and could be adopted in all high schools. Firm establishment and expansion of the Home Start program would enable access to the home by visitors who could provide educational and child-oriented services. Parent training courses in the public schools, and mental health education services by community mental health centers, both represent vehicles for primary prevention.

544. Belsky, J. (1978). A theoretical analysis of child abuse remediation strategies. *Journal of Clinical Child Psychology, 7*, 117–121.

Research on child maltreatment highlights three basic theoretical models to account for the etiology of child abuse and neglect: (a) the psychiatric model emphasizes the role of the individual abuser; (b) the sociological model highlights the role of social forces in abuse; and (c) the effect-of-child-on-caregiver model points toward the role the child plays in stimulating his or her own maltreatment. As a result of these differing perspectives, each model suggests distinctly different strategies for the prevention and treatment of child abuse. Approaches to remediating this social problem, founded on these three models, are critically examined. The author concludes that only strategies based on a serious consideration of all three models, and thus addressing problems of the abuser, the victim, and the society, can be successful in significantly reducing the incidence of child maltreatment. ©APA.

545. **Broadhurst, D.D. (1977). What can the schools do about child abuse? *Victimology, 2,* 316–322.**

The author maintains that there are at least four roles schools can play in the identification of child abuse and neglect: (a) reporter of suspected incidents, (b) partner in decisionmaking and treatment programs, (c) agency for primary prevention, and (d) child advocate. Case examples are presented to demonstrate how each role can be effected. ©APA.

546. Cohn, A.H. (1981). *An approach to preventing child abuse*. Chicago: National Commmittee for Preventing Child Abuse.

An approach to preventing child abuse established at the Conference on Child Abuse Prevention in December 1978 is presented. Background information on the causes and treatment of child abuse and the effectiveness of different prevention services is provided. The approach involves a system of supportive, training, and information programs for children and parents, including programs in perinatal support, early childhood screening and treatment, child care, mutual aid, crisis care, treatment for abused children, and adult and parent education. A strategy for implementing the approach by means of community activities is outlined.

547. Coolsen, P. (1980). Community involvement in the prevention of child abuse and neglect. *Children Today, 9,* 5–8.

Community involvement in the prevention of child abuse and neglect is discussed. Most concern about child abuse during the past two decades has focused on identification, reporting, and intervention. Primary prevention in child abuse refers to those efforts aimed at positively influencing parents before abuse takes place. Secondary prevention refers to those supportive services offered to parents who are considered to be at risk. Tertiary prevention refers to the services offered families after child abuse or neglect has occurred. An adequate community prevention program needs to develop strategies on all three levels. Child abuse, both cause and cure, is rooted in the community, its attitudes, its values, and its resources. A community prevention plan is given, including general goals, 11 prevention programs, and 4 community support activities.

548. **Davidson, A.T. (1977). Child abuse: Causes and prevention. *Journal of the National Medical Association, 69,* 817-820.**

Child abuse is defined, its history reviewed, and its causes and prevention examined. Child abuse is defined as maltreatment that affects the emotional, physical, or mental health of the child and which may be: collective--attitudes held by society concerning sex, race, and social status that impede the psychological and physical development of the child; institutional--all abusive and damaging acts perpetrated by schools, correctional systems, or social agencies; and individual--intentional acts of omission or commission by parents resulting in trauma to the child. Causes of individual child abuse include: low parental self-esteem, low frustration tolerance, impulsivity, dependency, immaturity, depression, and role reversals. The abused child is mostly male, under 3 years old, and somewhat different form other children. Situational stress or crisis is often associated with abuse/neglect. A comprehensive prevention program should include: parenting education for adolescents and adults; periodic screening, diagnosis, treatment, and followup programs; individual, family, and child counseling services; early identification and treatment of high-risk families and children; and parent self-help groups.

549. **Fontana, V.J. (1980). Child abuse: Prevention in teen-age parents. *New York State Journal of Medicine, 80,* 53-56.**

Child abuse by adolescent mothers is discussed. It is contended that pregnancy during adolescence involves serious medical, social, and economic consequences that may lead to the ultimate breakdown of the parent-child relationship and to child abuse. The maltreatment ranges from gross neglect, including starvation, to cruelty resulting in physical and emotional damage to the child. Stress factors on adolescent mothers are reviewed. It is argued that the extent of child abuse in the U.S. is the cause of deep concern, and early detection and prevention are emphasized, especially during the prenatal periods. Preventive techniques stress the quality of service and education.

550. **Garbarino, J. (1980). Preventing child maltreatment. In R. H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 63-79). Beverly Hills: Sage.**

Four propositions for addressing primary prevention of child maltreatment are presented: (1) remove or thwart the necessary conditions for child abuse and neglect while establishing a community climate that discourages the growth and maintenance of maltreatment; (2) concentrate on social rather than psychological forces; (3) humanize and reform aspects of our cultural and socioeconomic systems that undermine parental competence and sanction physical punishment; and (4) prevent the isolation of parents from prosocial support systems. The author presents five principal causes of child maltreatment: psychopathology; temperamental incompatability; perverse family dynamics; interpersonal deficiencies; and culturally based, inappropriate attitudes and expectations about childrearing and development. In view of these propositions and principal causes, it is suggested that efforts aimed at preventing child maltreatment be designed at the level of social networks, neighborhoods, communities, and the larger social system. This necessitates a movement away from one-on-one interventions and rehabilitation of individuals, and a move toward the identification of "high-risk" neighborhoods. It also necessitates professional activity as a community consultant and as a liaison between the existing or potential resources in the community and those who are in need of these resources.

551. **Garbarino, J. (1980). Changing hospital childbirth practices: A developmental perspective on prevention of child maltreatment. *American Journal of Orthopsychiatry, 50*, 588–597.**

This paper proposes that childbirth be viewed as a social rather than just a physiological or even psychological event. Modern American hospital childbirth practices are contrasted with family-centered birthings, which encourage early and varied contact between infants and mothers and the extended network of family and friends. A program is proposed, aimed at altering hospital policies and practice so that the birth of a child is treated as a more family-centered experience. Viewed in the broader context of community approaches to child protection, child welfare, and family development, building community support to stimulate and maintain institutional policies that enhance the potential of birth and the newborn period can serve to prevent child maltreatment.

552. **Gentry, C.F. (1978). Incestuous abuse of children: The need for an objective view. *Child Welfare, 57*, 355–364.**

The author discusses the need for more data on incestuous abuse of children and examines the victim's, the abuser's, and the family's response to the incestuous behavior. It is argued that family life education, screening of high-risk families, public education regarding the dependency of abusers, involvement of caring volunteers, and better coordination and accessibility of resources and support systems for families in need are required to prevent and/or reduce the prevalence of all types of child abuse, including incest. Some of the predictors of child sexual abuse are discussed. ©APA.

553. **Gil, D.G. (1975). Unraveling child abuse.** *American Journal of Orthopsychiatry, 45*, 346–356.

The dynamics of child abuse are examined, and approaches to primary prevention are suggested. Child abuse is redefined, within egalitarian value premises, as inflicted gaps in children's circumstances that prevent actualization of inherent potential. Levels of manifestation and causal dimensions of child abuse are identified, and their multiple interactions are traced. Primary prevention is shown to be essentially a political, rather than a purely technical or professional, issue. (Author abstract modified)

554. **Gil, D.G. (1976). Primary prevention of child abuse: A philosophical and political issue.** *Psychiatric Opinion 13,*, 30–34.

It is contended that, while amelioration of the problem of child abuse may involve important professional, administrative, and legal elements, the primary prevention of this destructive phenomenon, like that of any other serious social problem, is essentially a philosophical and political issue. The author contends that, as compared to child abuse in the home, quantitatively and qualitatively, more significant loci of child abuse can be identified at the institutional level where abuse of children is practiced through the policies and procedures of public settings and agencies. It is suggested that the requirements of primary prevention of child abuse amount to fundamental philosophical and structural changes of the prevailing social, economic, and political order.

555. **Gil, D.G. (1977). Child abuse: Levels of manifestation, causal dimensions and primary prevention.** *Victimology, 2*, 186–194.

Interactions among the levels of manifestation and the causal dimensions of child abuse are explored. Included in the levels of manifestation are abusive conditions in the home and abusive interaction between children and their caretakers. At the most fundamental causal level, child abuse is seen as a reflection of a society that allows exploitation and is nonegalitarian in nature. It is suggested that primary prevention would require basic changes in society's philosophy, including the elimination of poverty and psychological illness. The author concludes that prevention of child abuse is a political issue that cannot be resolved through professional and administrative measures.

556. **Grazio, T.F. (1981). New perspectives on child abuse/neglect community education.** ***Child Welfare, 60,*** **343–353.**

The task of sensitizing professionals and the general public to the problem of child abuse/neglect is addressed, and it is argued that education on this subject can be carried out properly only through the delineation of specific goals and strategies. Inadequacies in current practices are discussed, including the emphasis on increased reporting without increasing services, sensational approaches that lead to stereotypic thinking regarding child maltreatment, a witch hunt mentality, random scatter-gun tactics, and failure to address the agenda of community professionals. A Philadelphia service model, seen as enhancing the effectiveness of community education by using a multidisciplinary approach focusing on primary prevention issues, is described.

557. **Jackson, A.D.M. (1982). "Wednesday's children": A review of child abuse.** ***Journal of the Royal Society of Medicine, 75,*** **83–88.**

A selection of the important milestones in the recent history of child abuse prevention, chosen mainly from medical sources in the American and British literature, is reviewed; and certain aspects of child abuse that have a bearing on the way child abuse is dealt with in England are discussed. Areas covered include: non-accidental injury, psychosocial dwarfism, mother-infant bonding, prevention and treatment, followup studies, sexual abuse, unusual forms of abuse, interaction with the police, epidemiology, and official inquiries.

558. **Margrain, S.A. (1977). Review: Battered children, their parents, treatment and prevention.** ***Child Care, Health & Development, 3,*** **49–63.**

The author reviews the literature on battered children, their parents, and their management, treatment, and prevention. It is suggested that socioeconomic factors are less important than the psychology of the parent, who has often been a battered child himself. Management and treatment of the syndrome in the United Kingdom and the U.S. are outlined. An outline of the preventive and research projects in the field is presented. ©APA.

559. **Martin, H.P., & Beezley, P. (1974). Prevention and the consequences of child abuse.** ***Journal of Operational Psychiatry, 6,*** **68–77.**

The effect of the abusive environment on children is examined, stressing that this effect is variable and that multiple bases for the variation in sequelae must be understood and researched. Four such variables are identified and discussed: (1) the consequence of organic damage to the central nervous system as a result of physical trauma or undernutrition; (2) the associated factors in the home that have a deleterious effect on the child's development, apart from the abuse itself; (3) the importance of looking at the psychological needs of the child himself and the effect of treatment; and (4) prevention of child abuse by identifying high-risk children. The importance of anticipating and preventing abuse when possible cannot be overstated. Abuse is not an isolated physical trauma but a syndrome of altered and abnormal parent-child interactions that causes devastating damage to the abused child.

560. **Miller, C.C. (1981). Primary prevention of child mistreatment: Meeting a national need. *Child Welfare, 60,* 11-23.**

A framework for action on Federal, State, and local levels for providing primary prevention for the growing problem of child abuse and neglect is presented. Obstacles to increasing primary preventive activity include the shortage of resources, the historical basis for social service, definitional problems concerning both the concepts of prevention and the question of what constitutes abuse or neglect, eligibility requirements, lack of information about the impact of services, the narrow policy framework within which child welfare services are provided, and a fragmented constituency. Suggested lines of action related to policy, legislation, and capacity building are outlined.

561. **Miller, W.T. (1981). A special problem in primary prevention: The family that cares about their children but is not able to rear them. *Journal of Clinical Child Psychology, 10,* 38-41.**

The problems involved in primary prevention with grossly neglectful and/or abusive, "untreatable" but caring and attached families is described. When parents care about their child but are unable to rear them due to their own emotional or intellectual limitations, special ethical issues are evoked for those who plan help or must make decisions about these children and their families. It is essential that professionals deal with these dilemmas rather than avoid them. Historically, approaches that attempt to work with such families within the family systems have not been successful for those families with too few coping resources or too great family pathology. The most devastatingly destructive attempts to work within grossly inadequate family systems are seen in instances in which the children are removed repeatedly and then replaced with the family on the basis of a wish that the family could care for them. It is suggested that a kibbutz-like living arrangement might provide a better intervention/prevention model for working with these families. Such a model would protect the meaning of parent-child ties while providing for responsible care of the children. (Author abstract modified)

562. **Powell, D.R. (1980). Personal social networks as a focus for primary prevention of child mistreatment.** ***Infant Mental Health Journal, 1,*** **232-239.**

The nature and functions of social networks are explored as support systems, and the relationships between social networks and early childrearing are examined. The rationale and operational design of a primary prevention program that seeks to strengthen the social networks of parents of very young children are presented. It is concluded that personal social networks are important not only in mediating general life stress, but also in supporting parental childrearing responsibilities. Therefore, they can serve as primary preventives of child abuse.

563. **Prevention and Rehabilitation Work Group (1974). Report from the Prevention and Rehabilitation Work Group.** ***Clinical Proceedings, 30,*** **42-45.**

In the report from the Prevention and Rehabilitation Work Group of the National Conference on Child Abuse, the recommendation is made that any therapeutic or preventive program of families where child abuse or neglect occurs should be multidisciplinary with a comprehensive approach dealing with the entire family. Health professionals, educators, and social, legal, lay, and administrative personnel are suggested as being involved in any program. Comprehensive services, including crisis intervention, extended services, followup, and social, educational, and economic rehabilitation, are examined for both parents and children. Coordinating and evaluating the efforts involved in typical programs is stressed as a critical factor in maximal utilization of resources. The initiative for mandating and funding regional and local multidisciplinary programs of prevention and rehabilitation is suggested for the Federal Government.

564. **Solnit, A.J. (1980). Least harmful, most protective intervention.** ***Pediatrics, 65,*** **170-171.**

The viewpoint that, in order to maximize the prevention of child abuse, attractive, noncoercive health and social services should be provided to parents to strengthen their efforts to nurture their children, is presented. Such services should include health care, counseling, psychotherapy, and developmental evaluation and guidance. In providing child-centered services that are supportive of family needs, communities have a tendency to offer too little service too late or to intrude unnecessarily into the privacy of the family. However, respect for family privacy and the best interests of children are consonant with each other in the well-functioning family. The presumption that children's interests are best protected within the privacy of their family is contradicted when a child has suffered from serious physical or sexual injury.

565. Swift, C. (1979). The prevention of sexual child abuse: Focus on the perpetrator. *Journal of Clinical Child Psychology, 8*, 133–136.

In contrast to conventional approaches to the prevention of sexual assault, which focus on the victim, this paper presents two hypotheses relating to the development of sexual child abuse in male perpetrators, reviews empirical evidence supporting these hypotheses, and suggests approaches to the prevention of sexual child abuse based on these hypotheses. The hypotheses are that a large proportion of males who abuse children sexually (a) have been sexually abused themselves as chldren, and (b) are sexually ignorant and socially immature. ©APA.

566. Tableman, B. (1982). Infant mental health: A new frontier. *Infant Mental Health Journal 3*, 72–76.

Increases in the numbers of adolescent parents, single-parent families, and working mothers have placed more infants in conditions of increased risk. Similarly, surveys have shown that large percentages of pregnant women display attitudes, unrealistic expectations, and inappropriate parenting behavior that would seem to place their infants at risk for abuse and neglect. Current early intervention and parent education programs have often turned the baby over to the professional and downgraded the role of the parent, while day care programs are often characterized by high staff turnover and an instability of relationships. It is argued that what is needed is the development of a parent support system, community services, and social expectations that will help and protect young families. Supportive, educational/behavioral, and psychotherapeutic interventions are required. Home visiting appears to be the most effective, but group interventions are particularly valuable for teenagers. A parent support system requires staff commitment, should provide assistance in meeting real-life needs, and should reinforce the mother for active involvement with the infant. ©APA.

567. Wu, R.R. (1980). Stressors at birth. *Family & Community Health, 2*, 1–13.

Crucial variables leading to child neglect and abuse are traced to the neonatal period. Stress is seen as being positively associated with all pediatric social illness categories. Bonding and attachment of infant to caregiver are discussed in terms of symbolic interaction theory, and temporal and spatial components of the developing parent–child relationship are described. Research demonstrated that just 16 extra contact hours with the newborn infant during the first 3 post partum days had a positive effect on the mothers that persisted for 30 days. Means of facilitating bond formation and separation following bond formation are also discussed. It is concluded that effective parenting involves a reciprocal interaction between parent and child and that the most critical time to begin this relationship is during the period immediately following birth.

See also: 110, 350.

B. Screening and Intervention with Children Considered At-Risk for Abuse

568. **Ayoub, C., & Pfeifer, D.R. (1977). An approach to primary prevention: The "at-risk" program, *Children Today, 6*, 14–17.**

The at-risk program of the Hillcrest Medical Center, Tulsa, Oklahoma, was described to demonstrate an alternative approach to primary prevention of child neglect and child abuse. Three different segments of the program were identified and described: (1) inpatient screening of infants and children during the mother's pregnancy, when the child is born, or when a child is presented to the pediatric unit for hospitalization; (2) inpatient protocols and teaching programs on child and family health; and (3) the pediatric at-risk outpatient clinic. Program goals and characteristics of the children and families served were detailed. It is suggested that the at-risk program provides a realistic approach to child abuse prevention.

569. **Baker, B., Grant, J., Squires, J., Johnson, P., & Offerman, L. (1981). Parent aides as a preventive intervention strategy. *Children and Youth Services Review, 3*, 115–125.**

A Parent Aide program, designed to help parents of children at risk for abuse or neglect to cope better with childrearing problems, is described. While role modeling is used with all parents in the program, additional techniques and interventions are designed to meet client needs. An attempt is made to ensure flexibility of match between the aide and the parent. Meetings are regularly scheduled to include the parent aide coordinator, the client, the parent aide, the child protective worker, and involved others.

Ideally, parents remain in the program until they acquire enough self-esteem and confidence to cope with the stresses of daily living without taking their frustrations out on their children. Both aides and parents were interviewed to determine their perceptions of what activities are involved in the helping relationship and how crisis situations and problems are handled. A major finding is how aides can intervene in crisis situations and are able to work out temporary solutions to immediate problems without having to rely on foster care services. (Author abstract modified)

570. **Fields, S. (1976). Prevention of child abuse and neglect: III. Screening can be the mother of success.** ***Innovations*, *3*, 19–22.**

A report of a preventive child abuse program involving screening, evaluation, and clinical research in four prenatal and pediatric clinics in Chicago is presented. A test called the Maternal Personality Inventory (MPI) is used to identify at-risk mothers, who then receive a variety of appropriate therapeutic services. High scores in any two particular categories, such as rejection of pregnancy, hostility, depression, marital adjustment, relations with mother, and somatic symptoms, are believed to indicate a problem. A questionnaire for screening abusive fathers is being developed. A description of the preventive intervention and direct prevention services provided for at-risk families is included.

571. **Friedrich, W.N., & Boriskin, J.A. (1978). Primary prevention of child abuse: Focus on the special child.** ***Hospital and Community Psychiatry*, *29*, 248–251.**

This article reviews the literature on child abuse and presents evidence demonstrating that children who are born prematurely or who are sickly or handicapped are at high risk for child abuse. Ways to identify such children are described, and a number of primary prevention techniques that can reduce parental stress and help prevent child abuse are suggested. The techniques include day care programs for handicapped children, mothers' social clubs, and lay health visitors to give support and impart maternal attitudes. ©APA.

572. **Gabinet, L. (1979). Prevention of child abuse and neglect in an inner-city population: The program and the results.** ***Child Abuse & Neglect 3*, 809–817.**

A parental program for the prevention of child abuse and neglect in an inner-city population is described and evaluated. The program is for individual families referred by agencies that have made a tentative diagnosis of potential for child abuse. In most of these families, no reportable abuse had occurred at the time of referral. The program has obtained the cooperation of parents who do not admit or even recognize their abuse potential, and provides long-term, intensive treatment to a high-risk, lower-class population that would not get this help otherwise. A trained mental health assistant contacts the families and works to help them manage their lives better, avoid crises, improve impulse control, and improve self-esteem.

573. **Gray, J.D., Cutler, C.A., Dean, J.G., & Kempe, C.H. (1977). Prediction and prevention of child abuse and neglect. *Child Abuse and Neglect, 1*, 45–58.**

Utilizing an interview, a questionnaire, and observations during labor, delivery, and the post partum period, a sample of 100 mothers was identified as at high risk for abnormal parenting practices. These mothers were randomly divided into a "High-Risk Intervene" group (n=50) and a "High-Risk Nonintervene" group (n=50). The "Intervene" group received comprehensive pediatric followup by a physician, a lay health visitor, and/or a public health nurse in the home. The "Nonintervene" group received routine care. Another group of mothers who delivered during the same time period, and who were assessed as low risk in terms of abnormal parenting practices, served as controls. When the children were approximately 2 years old (mean age 26.8 months), 25 families in each of the 3 groups were chosen at random for detailed evaluation. Results indicated that (1) a high-risk group was successfully identified by the use of perinatal screening procedures (these children had encountered significantly different parenting practices than had the low-risk "control" group); (2) five children in the "High-Risk Nonintervene" group required hospitalization for serious injuries thought to be secondary to abnormal parenting practices, as contrasted with no such hospitalizations in the "High-Risk Intervene" and "Low-Risk" control groups; (3) labor-delivery observations, and nursery interviews and observations, provided the most accurate predictive information, while prenatal interviews and questionnaires did not add significantly. Perinatal assessment and simple intervention with families at high risk for abnormal parenting practices significantly improves the infants' chances for escaping physical injury. (Author abstract modified)

574. **Kempe, C.H. (1976). Approaches to preventing child abuse. The health visitors concept. *American Journal of Diseases of Children, 130*, 941–947.**

The development of children's rights is seen as beginning with the foundation of the first child health clinic in 1769. The first intervention in a case of child abuse took place in 1874. It is felt that innovation is now needed to assure children's rights. The likelihood of child neglect or abuse can be gauged by the results of prenatal, post partum, and family circumstance observations, and a special well-child care program for families judged as high-risk is presented. Four tables enumerating these observations and outlining the essentials of the program are presented. A system of lay health visitors is proposed for observation and prevention. The role of the health visitor is discussed. The author stresses that children should be given a good start by having access to a comprehensive health care program that ensures not only adequate physical health but adequate mental health as well.

575. **Lovens, H. D., & Rako, J. (1975). A community approach to the prevention of child abuse. *Child Welfare, 54*, 83–87.**

This paper describes a suburban community's effort to identify and intervene in situations where children are designated as "vulnerable" or at risk for child abuse. As a way of preventing abuse and neglect, a community program enlisted the cooperation of six hospitals in order to set up a cross-index referral system to identify children. The goals of the program include developing an effective communication system among professionals in the community, setting guidelines for early identification of vulnerable children, providing consultation and education to the community, and developing a central index for cross-indexing among hospitals and agencies. Several cases that illustrate the usefulness of this program in preventing further abuse are presented.

576. **Milner, J. S., & Ayoub, C. (1980). Evaluation of "at risk" parents using the Child Abuse Potential Inventory. *Journal of Clinical Psychology, 36*, 945–948.**

The author investigated the ability of the Child Abuse Potential Inventory (CAPI) to distinguish at-risk individuals. During a 2-year period the CAPI was given to 67 at-risk parents who were participating in an at-risk parent-child program. Ss were judged as at-risk when they met one or more of the at-risk criteria that had been developed by the program (e.g., low-birthweight infant, parental abuse of drugs or alcohol, and family or marital crises). Sixty-four of the Ss completed the CAPI. Forty-five percent of the at-risk sample had CAPI scores above the 95th percentile of the norm group. Strengths and weaknesses involved in the labeling of Ss as at risk using the at-risk criteria and the CAPI are discussed. ©APA.

577. **Thomasson, E., Minor, S., McCord, D., Berkovitz, T., Cassel, G., & Milner, J.S. (1981). Evaluation of a family life education program for rural high-risk families. *Journal of Community Psychology, 9,* 246-249.**

The effectiveness of a 16-session family life education program for high-risk rural families was evaluated in 79 participants. The program was based on an ecological model of child abuse; its components included education, communication skills training, ancillary income support, and child care services. The participants met weekly and attended both large group presentations and small group discussions. The Child Abuse Potential Inventory and a questionnaire were used to evaluate program effectiveness. The inventory, which was administered as a pretest and a posttest, showed a significant decrease on abuse scores across the program. A 7-week followup with the same inventory indicates that the decrease in abuse scores was maintained. Data from the questionnaire show that participants enjoyed the program and that they acquired information about child development, parenting skills, and available community resouces. (Author abstract modified)

See also: 336, 388, 550, 552, 559.

C. Descriptions of Programs

578. **Bailey, B. (1977). Child abuse: Causes, effect and prevention. *Victimology, 2,* 337-342.**

Three ongoing child abuse studies are outlined in brief, including analysis of a child abuse primary prevention project. This project was an informational campaign designed to raise the level of knowledge about child abuse in a community. They found the greatest gain in knowledge, as measured in preintervention and postintervention assessments, among the lower SES group. The importance of evaluative studies to assess a program's effectiveness is stressed. The program itself is not described.

579. **Comstock, C.H. (1982). Preventive processes in self-help groups: Parents anonymous. *Prevention in Human Services, 1,* 47-54.**

A series of vignettes illustrates how the group process in Parents Anonymous provides participants with opportunities to change their feelings and behavior. These vignettes focus on concepts of self-worth, love, touching, and blocked feelings. Through these processes and an atmosphere of mutual sharing and support, Parents Anonymous may prevent continued or potential child abuse. (Author Abstract) ©The Haworth Press.

580. **Galdston, R. (1975). Preventing the abuse of little children: The parents' center project for the study and prevention of child abuse. *American Journal of Orthopsychiatry, 45,* 372–381.**

Forty-six families with 73 children between the ages of 6 months and 4 years were treated in a project developed to preserve the integrity of the family while protecting the child from physical abuse. Improvement in the rate of growth and development was found among the children. There was much less improvement in the domestic functioning of their parents. However, it appeared that the parents would not have kept their children in the project if they had not been in concurrent treatment. (Author abstract) ©American Orthopsychiatric Association.

581. **Gray, E.B. (1982). Perinatal support programs: A strategy for the primary prevention of child abuse. *Journal of Primary Prevention, 2,* 138–152.**

Perinatal support programs are considered as a strategy for the primary prevention of child abuse. Research stimulating such programs is reviewed, including studies of the abilities of neonates and infant-environment interactions, mother-infant bonding and interactions, and ethological studies of the relationship between aggression and love. The prescribed components of perinatal programs, according to the Interprofessional Task Force on Health Care of Women and Children and the National Committee for the Prevention of Child Abuse, include childbirth preparation for prospective parents and education for obstetricians and staff; family-centered programs within the maternity unit; the provision of education and support during the post partum period to foster comfort and attachment between parents and child; and followup programming. Four demonstration programs are described: the Perinatal Positive Parenting Program, an educational and supportive program for new parents; a Vanderbilt University program to demonstrate three variations in increased post partum contact between parent and child and to establish protocols for hospital implementation of increased contact; the Rural Family Support Project, a systems approach to encourage perinatal support programming; and the Pride in Parenthood Program, which utilizes "family friends" as an education and support resource for inner-city couples expecting their first child. (Author abstract modified) ©Human Sciences Press.

582. **Haditono, S.R. (1981). Prevention and treatment of child abuse and neglect among children under five years of age in Indonesia.** ***Child Abuse & Neglect*, 5, 97–101.**

Child abuse and neglect in Indonesia are discussed, and attempts at prevention and treatment of child victims under 5 years of age are described. At present, no specific laws protect children from abuse and neglect. Because of Moslem religious beliefs concerning premarital sex, children born out of wedlock are particularly at risk. Child labor, child trials, and infanticide are among problems in this area in Indonesia. Sayab Ibu, a social institution, provides services, including temporary shelter for neglected children and adoption for young children abandoned or voluntarily placed by their parents. Another institution, Kasih Sayang Anak, provides similar services for children and infants under two. Both institutions have requirements for adoptive parents aimed at ensuring the child a home with parents who are physically, financially, and emotionally able to provide a nurturing environment.

583. **National Center for Child Abuse and Neglect (1978).** ***Child abuse and neglect prevention and treatment in rural communities: Two approaches*. (DHEW Pub. No. (OHDS) 78–30154). Washington, DC: U.S. Government Printing Office.**

Two reports that address the problem of how to enhance the prevention and treatment of child abuse and neglect in rural areas are presented. The first, "A Rural Community Self-help Approach to the Prevention of Child Abuse and Neglect," was produced by the Appalachian Citizens for Children's Rights. The report covers: (1) the legal responsibility to report instances of child abuse and neglect, (2) the skills necessary to identify abuse and neglect, (3) the official responsibility of public agencies, and (4) the pervasiveness of the problems. A model for child abuse and neglect services to serve rural areas, which have different problems than urban areas, was developed. The second report, "Operation Reach---Wyoming People Reaching Out to Help Their Abused and Neglected Children," was prepared by the Wyoming Department of Health and Social Services. The report describes the effects of Operation Reach, which was designed to solicit increased public involvement at the local level in dealing with the problem of child abuse and neglect.

584. **Robbins, M. (1982). Project Nak-nec-we-sha: A preventive intervention in child abuse and neglect among a Pacific Northwest Indian Community. In S.P. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 233-249). Portland, OR: Oregon Health Sciences University.**

This article describes a project involving child abuse/neglect on the Yakima Indian Reservation. The need for preventive service in this area is documented, and the service delivery system that emerged to deal with the situation is described. Heavy emphasis was placed on the use of indigenous resources. The objectives of the project included efforts to keep the children in their kinship system rather than removing them to external placements, and intervention efforts focused on the family unit in which the abused/neglect occurred. Causes of the abuse/neglect were found to include the following: domestic quarrels; lack of sufficient resources; excessive use of alcohol; and inappropriate response to the family by the legal, educational, or larger social systems. In addition, efforts of community education and the development of educational services directed toward developing positive alternatives for parents are described. Finally, the relationship of this program to the existing service delivery is described, and conflicts are noted.

585. **Solomons, G., Abel, C.M., & Epley, S. (1981). A community development approach to the prevention of institutional and societal child maltreatment. *Child Abuse & Neglect, 5*, 135-140.**

The Community/Institutional Development (CID) system has been implemented to address the needs of children placed in out-of-home care facilities. The major purpose of the system is to prevent the occurrence of institutional and societal child maltreatment. It features community/institutional collaboration in the review of the institutionalized child's care and the development of programs to prevent child maltreatment. This would represent a genuine collaboration between institutions and their communities, assessing the contributions of both to the quality of child care. At this time, CID is a pilot project in the State of Kansas only. There are a total of eight public and private child care institutions involved. (Author abstract modified)

VIII. Prevention within the Family System

Articles in this category involve efforts at primary prevention by working with couples and/or families. Interventions have attempted to improve marital or family relations or prevent marital or family problems. Many of the interventions described have a mental health promotion rather than a disease prevention focus.

A. Couples

586. David, H.P. (1980). Healthy family coping: Transnational perspectives. In L.A. Bond, & J.M. Joffe (Eds.), *Primary prevention of psychopathology, Vol. 4: Competency and coping during adulthood* (pp. 332–365). Hanover, NH: University Press of New England.

Prevailing concepts of the family, family health, and healthy family functioning amidst environmental stress are examined from a transnational perspective. Focus is on the interrelationships between healthy family coping, conception control, and socioeconomic development. It is contended that prevention promotion requires recognition of sociopolitical realities and a redirection of resources. A need for better utilization of already available knowledge is also emphasized. Using these observations, a program of cooperative transnational research with newly married couples is proposed. It utilizes the concepts of choice behavior, the decisionmaking process, and research planning to develop a cross-cultural approach for identifying behavioral attributes of healthy family functioning in the early years of marriage and for studying coping behavior in developed and developing countries.

587. Hinkle, E., & Moore, M. (1971). A student couples program. *Family Coordinator, 20*, 153–158.

A relationship enrichment workshop developed and conducted for married and engaged college students is described. The workshop is for healthy couples and not primarily rehabilitative in nature. Rather, the goal of the workshop is to teach participants some concepts and exercises for improving their mutual communication, including expression of affection and constructive fighting. It is hoped that this paper will encourage more preventive mental health programs for married adults and those contemplating matrimony. (Author abstract modified)

588. **Markman, H.J., & Floyd, F. (1980). Possibilities for the prevention of marital discord: A behavioral perspective. *American Journal of Family Therapy, 8*, 29–48.**

A model of prevention research that stresses the importance of empirically derived interventions is developed and applied to the program of preventing marital distress. The empirical evidence on the role of communication factors in the development of marital problems is reviewed. The research indicates that communication deficits are associated with the development and maintenance of marital distress. A behavioral premarital intervention program that is based on these findings and the techniques developed by behavioral marital therapists is presented. This program is designed to enhance communication and problem-solving skills and to improve the couples' future satisfaction and communication patterns. The preliminary short-term results of the intervention program are presented and a few methodological and conceptual issues that need to be considered in evaluating the short-term impact of such programs are discussed.

589. Wetzel, J.W. (1980). Preventing mental illness through existential principles. *Journal of Religion and Health, 19*, 268–274.

The use of existential principles in marital counseling to prevent mental illness is discussed. The application of the existential principle of abundance is put forth for the purpose of developing genuine mutual support, personal awareness, and authenticity leading to the prevention of mental illness. The application of the principle of abundance positively reinforces mental health by increasing competence and self-esteem and establishing helping networks that prevent mental illness. (Author abstract modified)

See also: 502.

B. Families

590. Ackerman, N.W. (1961). Preventive implications of family research. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 142-167). New York: Basic Books.

In order to understand the emotional illness or health of children, it is suggested that the functioning of the family unit must be assessed. A conceptual model including the characteristics found in healthy family units as well as the developmental process of the child's integration into the family group is presented. Distortions of family and child development such as scapegoating, role confusion, and incest are discussed. It is suggested that families can be studied using such techniques as family interviews, psychological and psychiatric evaluations, and home visits. It is recommended that professionals working with families be well trained in family psychotherapy, social treatment, and family life education techniques.

591. **Anderson, E.E., & Wentworth, Q. (1983). Young children in alcoholic families: A mental health needs assessment and an intervention/prevention strategy.** ***Journal of Primary Prevention, 3,*** **174-187.**

This article discusses preventive intervention with alcoholic families and, in particular, involvement in working with young children of these families to help them better deal with the stress and problems created by one or more alcoholic parents. The unique problems that these young children face, the level of these problems, and the types of coping strategies that can be taught to them are discussed.

592. **Bolman, W.M. (1968). Preventive psychiatry for the family: Theory, approaches, and programs.** ***American Journal of Psychiatry, 125,*** 458-472.

The author attempts to connect theory, generally programmatic approaches, and specific programs related to family-oriented preventive programs in a systematic and meaningful way. His theoretical framework views the family as a flexible social organization, an open system subject to stress from its environment, which includes biologic, intrapsychic, and interpersonal forces as well as sociologic and community levels. (Author abstract)

593. Carnes, P.J., & Laube, H. (1975). Becoming us: An experiment in family learning and teaching. *Small Group Behavior, 6,* 106-120.

The article describes a program of training in family communication skills based on systems theory. "Trainer families" teach communication skills (e.g., listening, speaking, value sharing, problem solving, and contracting) to other families through role playing, modeling, practice, and processing. The goal is described as an improved family self-concept. ©APA.

594. **Hasenfield, H., Murphy, S. & Olson, K. (1981). The child parent drop-in center: Community based primary prevention. *Infant Mental Health Journal, 2,* 155-158.**

The article describes a community child-parent drop-in program that provides services to families with few financial resources or to those who may not seek help from other service agencies. The family-oriented program provides short-term care for children from birth to kindergarten age, short-term counseling, educational programs and social opportunities for parents, and referral to other community resources. Parents, students, and senior citizens are actively involved in the program. ©APA.

595. **Heller, M. (1975). Preventive mental health services for families new to the community. *Hospital and Community Psychiatry, 26,* 493-494.**

A program designed to offer indirect, preventive services for families relocating in a new community is the focus of this paper. It is argued that problems associated with relocation cause pressures that create intrafamily disturbances, which in turn may adversely affect children's educational, emotional, and social growth. The Staten Island Children's Community Mental Health Center offered group sessions for parents of children in Staten Island elementary schools. Their goal was to help parents with their concerns about their children, to ease day-to-day frustrations, and, in so doing, to prevent the need for long-term help. Ten 90-minute weekly group sessions were held for approximately 15 groups of parents. The format for sessions was child-centered discussion by the parents. Parents reported gaining insight into their children's behavior and support from the other parents. The most satisfying aspect of the discussions for many parents was finding that their concerns were shared by others. The program is now an integral part of the work of the consultation and education division of the center.

596. Kane, R.P. (1982). The family's role in primary prevention. *Journal of Children in Contemporary Society, 14,* 27-34.

This article examines family intervention in terms of an early intervention primary prevention model. When a family is in some crisis or disequilibrium, the caregiver may intervene not only to help the family progressively resolve its crisis, but also to strengthen the family's coping capacities. Anticipatory guidance, strengths, needs, and support are some suggested ways of coping. Developmental aspects of child and family are illustrated by a case example. ©APA.

597. Langsley, D.G. (1978). Three models of family therapy: Prevention, crisis treatment or rehabilitation. *Journal of Clinical Psychiatry, 39*, 792–796.

This article describes models of intervention at a family level: preventive, crisis intervention, or rehabilitative. The preventive model suggests that certain stresses produce family disorganization, and individual family members may regress to symptoms of disease. Family dysfunction could be avoided through identification of high-risk groups and intervention at developmental milestones. Crisis intervention, the second model, suggests that early identification and prompt intervention may avoid the development of more serious disorganization. The rehabilitative model is focused on changing long-term patterns of maladaptive behavior. It includes the homeostasis model, the conflict resolution model, and other approaches to long-term family therapy. ©APA.

598. **Levant, R.F. (1978). Client-centered approaches to working with the family: An overview of new developments in therapeutic, educational, and preventive methods. *American Journal of Family Therapy, 6*, 31–44.**

This paper presents an overview of recently developed client-centered helping programs for the family. These programs include a client-centered form of family therapy and three types of family educational programs: (a) training family members as helping persons who provide therapy to another family member; (b) using training as the treatment itself, for the remediation of dysfunctional family relationships; and (c) training for prevention of family and emotional problems. These programs are described, and the evaluative research findings are presented and assessed. ©APA.

599. **Satir, V.M. (1975). Family life education: A perspective on the educator. *Small Group Behavior, 6*, 3–10.**

The article describes contemporary society and the breakdown of the modern family as indicators of a need for preventive family life education. A qualified family life educator is described as one who teaches people how to discover their "humanness." This discovery entails using individual differences creatively, living by internal norms, accepting anger as a valid emotion, and learning ways to enhance self-esteem. ©APA.

600. **Schwartz, R.A. (1969). The role of family planning in the primary prevention of mental illness.** ***American Journal of Psychiatry, 125*****, 1711-1718.**

This article reviews a number of issues related to family planning and their possible contributions to mental illness. Included are: the unwanted child, illegitimacy, premarital pregnancy, poverty, post partum psychosis, and excessive population growth. After establishing the role that family planning can play in preventive psychiatry, the author discusses existing family planning programs and the need for services. He suggests that a possible way to begin to satisfy the unmet need is to increase the role played by mental health facilities. Case-finding is identified as one of the major potential contributions. In addition, providing education and acting as a referral source are suggested. It is also pointed out that in some cases the provision of direct services may be appropriate.

601. **Simon, D.S. (1976). A systematic approach to family life education.** ***Social Casework, 57*****, 511-516.**

The author describes a social service agency's prevention-oriented program to strengthen family life and promote healthy functioning of members. Community needs were identified and group processes used to deal with these needs through education. ©APA.

602. **Spoon, D., & Southwick, J. (1972). Promoting mental health through family life education.** ***Family Coordinator, 21*****, 279-286.**

The operation of a family life education program and its relationship to the sponsoring community mental health center's treatment services are discussed. The objective of the program developed by the North Central Kansan Guidance Center is the promotion of mental health in mentally healthy families. The need to provide primary prevention in mental health by agencies involved in mental health services is stressed. The emphasis is on learning, understanding, and promoting practical techniques of individual, family, and social living. Various methods for securing participants for the program, which consists of eight 2-hour meetings, are discussed. An evaluation of the effectiveness of this family life education program is presented.

603. **Tendler, D., & Metzger, K. (1978). Training in prevention: An educational model for social work students.** ***Social Work in Health Care, 4*****, 221-231.**

Graduate schools of social work have made infrequent use of public health settings as a locus for practical education and a particular resource for learning in prevention. This report is on a project aimed at the development of an educational model in preventive work with families and children, using a student unit in fieldwork in a county health department. The 3-year project emphasizes early intervention with concern for developmental and life-cycle tasks of families. Ongoing evaluation of process indicates clearer identification of populations at risk and changes in student appreciation of collaborative roles with other disciplines in patient care, as well as specific learning of tasks and roles associated with screening, case finding, referral, and treatment. (Author abstract)

604. **Vaughan, Jr., W.T., Huntington, D.S., Samuels, T.E., Bilmes, M., & Shapiro, M.I. (1975). Family Mental Health Maintenance: A new approach to primary prevention. *Hospital and Community Psychiatry, 26,* 503-508.**

An approach to primary prevention is described in which indirect services are redefined to include community services aimed at promoting mental health and preventing emotional and mental disorders. At the Peninsula Hospital Community Mental Health Center such services are family focused and include consultation, education, collaboration with other agencies, and early intervention with children and families with special needs. Some of the programs that have been developed are described. The way mental health centers can conceivably develop such community services for health maintenance organizations and other prepayment plans is discussed.

605. **Wagner, M. (1978). *Denmark's National Family Guidance Program: A preventive mental health program for children and families.* (DHEW Pub. No. (ADM) 77-512). Washington, DC: U.S. Government Printing Office.**

Denmark's 10-year experience with the national Family Guidance Program, which may be the only attempt to date to provide a nationwide mental health program of services to families in crisis so as to prevent or minimize the impact of the crisis on the development of the families' children, is described and analyzed. It is suggested that the most important lesson to be learned from the Danish experience is that a nationwide support system for families with children is feasible; furthermore, such a system is comparatively cheap and can have a high degree of acceptance both from the providers and the consumers. It was found that one effective way to organize a family support system is through central planning and monitoring and local administration and service delivery. Family support services should emanate from the neighborhood so that workers are familiar with local conditions and resources. Larger cities must be divided into local neighborhoods and the program must be decentralized to these neighborhoods. Also, a family support system should have an emergency service through which families in crisis can be assisted on the same day they apply.

See also: 104, 120, 196, 231, 248, 337, 378, 427, 506, 514, 526, 561, 596, 607, 613, 637, 649, 681, 684, 698, 701, 702, 787, 903.

IX. Primary Prevention with Specific Populations

Articles within this category involve descriptions of primary preventive interventions with specific populations. These specific populations include various minority groups, the elderly, and other populations such as deaf or handicapped individuals.

A. Minorities

1. American Indians

606. **Dinges, N. (1982). Mental health promotion with Navajo families. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 119–141). Portland, OR: Oregon Health Sciences University.**

This paper reports on a program of mental health promotion for Navajo families. The participants were contemporary Navajo families faced with the task of social survival and the preparation of their children to cope with a rapidly changing intercultural world. The author describes how the project sought to integrate with the culture of the Navajo and was based on the belief that "since one of the goods of mental health promotion is to optimize culturally accepted forms of interpersonal behavior, it is important to understand the Navajo concept of approved social behavior." A transcultural model is described and is combined with a developmental view of the family as a social system to form the conceptual framework for a parent–child interaction program. Examples of the intervention are given, via case study, and its evolution suggests that it yielded many positive effects, though some aspects of outcome did not differentiate families in the intervention group from a comparison group.

607. **Dinges, N.G., Yazzie, M.L., & Tollefson, G.D. (1974). Developmental intervention for Navajo family mental health. *Personnel and Guidance Journal, 52,* 390–395.**

A transcultural approach to implementing a strategy of preventive intervention for enhancing the mental health of isolated Navajo families is described. The program utilizes a curriculum of culturally relevant interaction activities that were based on in-depth interviews with 72 families designed to identify Navajo mental health values, assess childrearing practices and attitudes, and understand the Navajo approach to the socialization of young children. Interaction activities, which focus on the relationship between Navajo children and their parents, are delivered by Navajo paraprofessional family intervention counselors who visit families on a weekly basis. Counselors use developmental screening tests to provide a basis for parent–child interaction activity selection. Extensive evaluation of the project is planned. (Author abstract modified)

608. **Haven, G.A., & Imotichey, P.J. (1979). Mental health services for American Indians: The USET program. *White Cloud Journal, 1,* 3–5.**

A report on the United Southern and Eastern Tribes (USET) mental health service programs for American Indians is presented. Fourteen USET mental health programs operate in an area that covers virtually the entire eastern half of the United States. The USET program is directed toward community prevention with a major focus on the treatment of alcoholism. Each of the 14 programs is a tribal or Indian group project. Coordination and consultation is provided by the Southeastern Regional Health Board and the Standing Committee on Mental Health and Substance Abuse. USET's approach is to develop human service departments and workers in the mental health area who will serve in prevention and treatment roles without programmatically differentiating mental health, alcoholism, and substance abuse. The status of the individual programs is summarized with regard to population served and services available.

609. **Kleinfeld, J. (1982). Getting it together at adolescence: Case studies of positive socializing environments for Eskimo youth. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 341–365). Portland, OR: Oregon Health Sciences University.**

This article asserts that much that is relevant to prevention can be learned from studying those naturally occurring settings which appear to have a positive impact on high-risk populations.

The author describes two such settings, a Catholic boarding school for Eskimo adolescents and an indigenous Eskimo village youth organization funded and directed by its local community. Both show evidence of developing varied competencies in adolescents related to later successful adaptation. Both include an integrated framework, clear character ideals, and the skills required to plan and organize community projects. While the two settings are themselves quite different, both provide culture-congruent experiences and active role models for the adolescents.

610. **Lefley, H.P. (1982). Self-perception and primary prevention for American Indians. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 65-89). Portland, OR: Oregon Health Sciences University.**

This paper builds on a series of studies involving the assessment of American Indian self-concept and the development of an intervention program designed to raise self-esteem. The author stresses how important it is to regard both the measurement of self-esteem and its behavioral correlates as being culturally defined and asserts that results of the reported studies suggest low self-esteem in Indian children is related to two major independent variables: the acculturation/tribal-disintegration process and the attendant role and identity conflict regarding loneliness. Possible prevention programs are outlined, with much attention centering on the importance of confronting the relationship of American and Alaskan Native communities to the white superstructure.

611. **Manson, S.M., Tatum, S.E., & Dinges, G. (1982). Prevention research among American Indian and Alaska native communities. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 11-62). Portland, OR: Oregon Health Sciences University.**

This article provides a summary of prevention research involving American Indian and Alaskan Native communities. The authors describe prevention research in terms of six conceptual domains, including (a) health promotion, (b) disease prevention, (c) the presumed locus of the phenomenon of interest--primarily personological or situational, (d) motives about time and the timing of interventions, (e) the nature of the phenomenona relevant to prevention research, and (f) varied strategies of change. A selective literature review follows, including preventive research and intervention in the areas of alcoholism, drug abuse, delinquency, child abuse and neglect, major and minor psychiatric disorders, mental retardation, suicide, and the development of generalized competencies. In conclusion, the authors advocate the importance of a culture-embedded approach to competence development, using a perspective that regards behavior as a three-way, reciprocal interaction between behavior, internal personal factors such as the self-system, and environmental influences.

612. **Mohatt, G., & Blue, A.W. (1982). Primary prevention as it relates to traditionality and empirical measures of social deviance. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 91-116). Portland, OR: Oregon Health Sciences University.**

This article describes a research and community intervention project with the Lakota Sioux. The research involved the creation of a scale designed to assess *tiospaye*, a Sioux word describing a traditional community way of life patterned by Lakota Sioux rules for social interaction, rituals for transition, identity acquisition, healing, and a set of values. This scale was then correlated with indicators of psychopathology and levels of psychopathology over a 3-year period, using two communites as a sample. In addition, one community was chosen as a site for intervention, where the research team worked with community leaders and other residents to build a *tiospaye*.

613. **Red Horse, J. (1982). American Indian Community mental health: A primary prevention strategy. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 173-185). Portland, OR: Oregon Health Sciences University.**

This article outlines a strategy for approaching preventive interventions with American Indian populations. The first section of the paper reviews conceptual themes relevant to prevention with Indian populations, including the importance of supporting the values of cultural heterogeneity, viewing behavior as involving the transaction between individuals and communities, and adopting a social system perspective. The second section outlines a model that helps organize information on community assessment and includes seven components: life situations, family lifestyle, cultural cohesion, geographical and population characteristics, mediating structures, institutional arrangements, and coping outcomes. The third section describes a family mental health program with Indian families based on the components of the previously described model.

614. **Shore, J.H., & Nicholls, W.M. (1975). Indian children and tribal group homes: New interpretations of the Whipper Man. *American Journal of Psychiatry, 132*, 454–456.**

The authors describe a community-based children's home and child welfare program among a tribe of Plateau Indians. It is suggested that the program has been effective because it is compatible with this Indian culture's acceptance of the extended family and community responsibility for child care. The program demonstrates principles of primary prevention in community mental health. ©APA.

615. **Shore, J.H., & Keepers, G. (1982). Examples of evaluation research in delivering preventive mental health services to Indian youth. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 325–337). Portland, OR: Oregon Health Sciences University.**

The authors of this article discuss the manner in which tertiary, secondary, and primary prevention programs can represent different stages of inquiry that can be additive. They take the perspective that "it is important to systematically work from a classification of symptoms in a patient or student group towards an earlier stage of case identification. This allows integration of prevention efforts at any level in a service delivery system and avoids a polarization between prevention and other approaches" (p. 330). Using evaluations of a boarding-school dropout project, model dormitory project, and a tribal group home, the authors clarify how the data gathered in these projects helped make the transition from tertiary and secondary levels of prevention to primary prevention activities.

616. **Torrey, E.F. (1970). Mental Health Services for American Indians and Eskimos, *Community Mental Health Journal, 6*, 455–463.**

Past and present mental health services for American Indians and Eskimos are reviewed and found to be inadequate. A plan is outlined for the development of such services based on a cooperative, rather than a paternalistic, venture with these minority groups. The plan is based on the use of indigenous therapists for individual and group psychotherapy, the modification of etiological beliefs, and an emphasis on primary prevention. The Alaskan Eskimo is used to illustrate how these principles could be put into effect. The outcome would be a system of mental health services specifically adapted to the culture, realistically commensurate with available manpower, and compatible with dignity for the group. (Author abstract) ©Human Sciences Press.

617. **Trimble, J.E. (1982). American Indian mental health and the role of training for prevention. In S.M. Manson (Ed.), *New directions in prevention among American Indian and Alaska native communities* (pp. 147–168). Portland, OR: Oregon Health Sciences University.**

This article outlines the need for the training of persons to work in preventive roles with American Indians, with a primary emphasis on the importance of understanding Indian cultures. "Maintaining Cultural Encapsulation" is the phrase used by the author to characterize current training models that dominate American psychology at present, and examples of alternative training models that are responsive to cultural diversity are discussed. The area of substance abuse is cited as potentially important for prevention training with American Indians. The need for skilled, culturally sensitive counselors in the mental health field is documented, and recommendations for increasing both the cultural validity of psychological knowledge and the quantity of American Indians working in the mental health field are presented.

618. **Tyler, J.D., & Dreyer, S.F. (1975). Planning primary prevention strategy: A survey of the effects of business location on Indian reservation life. *American Journal of Community Psychology, 3*, 69–76.**

The impact of business development on community life on American Indian reservations was examined. It was hypothesized that the introduction of new business or industry into a high poverty level Indian reservation community would have both positive and negative effects on mental health. Answers to questionnaires sent to all field offices of the Bureau of Indian Affairs cited approximately twice as many positive effects as negative effects. It was also found that relatively few Indians were actually employed and consequently exposed to either type of effect. Implications of the survey for planning primary prevention strategies that would minimize the pathogenic influences of business development are discussed.

See also: 957.

2. Blacks

619. **Bloom, M. (1983). Prevention/promotion with minorities. *Journal of Primary Prevention, 3*, 224–234.**

This article focuses on the prevention of social problems and the promotion of social functioning for black Americans. Various institutional forms are identified along with strategies for prevention/promotion appropriate to each. These institutions include the black family, church, education, business, and military. Prevention is seen as an activity for self-help groups with professionals serving as organizational catalysts.

620. **Brooks, C.M. (1974). New mental health perspectives in the Black community. *Social Casework, 55*, 489-496.**

A workable model of nontraditional approaches to human service delivery geared to community and individual needs is described in a developmental history. The project is based in a predominantly black urban area in a public housing program serving primarily welfare recipients and low-income clients. Focus is on public meetings, newspaper communication, education and prevention programs (including family night activity, preschool program, and mothers' group), and treatment programs. It is shown that mental health services to the urban poor require the creation of a whole new concept of service delivery, with emphasis on building self-esteem and working to improve the degrading conditions under which the poor live.

621. **Carter, J.H. (1981). Treating Black patients: The risks of ignoring critical social issues. *Hospital and Community Psychiatry, 32*, 281-282.**

The importance of social issues in the provision of mental health services to blacks is discussed. Many blacks are affected by the emotional consequences of racism, poverty, and economic stress, which, combined with the unresponsiveness of health systems, results in the perpetuation of preventable disabilities. Future treatment must embrace aspects of black culture, sociopsychological factors, and physical health as determinants of the manifest psychopathology. Although treatment is important, greater emphasis should be placed on prevention when planning the community mental health center programs of the 80s.

622. **Hilliard, T. O. (1981). Political and social action in the prevention of psychopathology of Blacks: A mental health strategy for oppressed people. In J. M. Joffe, & G. W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 135-152). Hanover, NH: University Press of New England.**

The author points out that major theories of personality have failed to take into account the effects of variables such as racism and poverty in the development of personality and psychopathology in blacks and other minorities. The author provides a frame of reference for black psychology that includes discussion of philosophical assumptions, a historical perspective of blacks that encompasses both African heritage and experiences in America, and a discussion of political and economic factors that influence blacks. The point of view expressed by the author is that the mental health of blacks is inextricably tied to the overall economic, political, and social status of black people. According to the author, only a substantial reduction in the political and economic oppression of blacks will lead to an overall improvement in their mental health.

623. **Neighbors, H.W., Jackson, J.S., Bowman, P.J., & Gurin, G. (1983). Stress, coping and Black mental health: Preliminary findings from a natural study. *Prevention in Human Services, 2*, 5–30.**

Despite the fact that blacks are disproportionately exposed to social conditions considered to be antecedents of psychiatric disorder, epidemiologic studies have not conclusively demonstrated that blacks exhibit higher rates of mental illness than whites. The present paper employed a research approach that considered not only rates of psychological distress, but also the stressors the blacks face and the various coping strategies used to adapt to those stressors. The data were obtained from the National Survey of Black Americans, the first study of a national probability sample of the adult black population. The information on mental health and coping was collected within the context of a single stressful personal problem. The analysis indicated that prayer was an extremely important coping response used by blacks, especially among those making less than $10,000, above the age of 55, and female. The informal social network was used quite extensively as a means of coping with problems. This was true for all sociodemographic groups studied. The young (18–34) were less likely than those age 35 and above to seek professional help, while women were more likely than men to seek formal assistance. Income was not related to professional help seeking with respect to the use of specific professional help sources. Hospital emergency rooms, private physicians, and ministers were used most frequently. The implications of these findings for research on mental health and primary prevention are discussed. (Author abstract)

624. **Paul, B.B. (1981). Prevention: One community's approach. In J. Gordon (Ed.), *Reaching troubled youth*. (DHHS Pub. No. (ADM) 81–955). Washington, DC: U.S. Government Printing Office.**

A community-based program in upstate New York, which provides counseling, referral, and crisis intervention to inner-city youth and their families, is described. The Youth Project has recently merged with a traditional mental health facility for children and adolescents in Rochester, New York. About 98 percent of the clients were black youth referred from the nine schools in the area.

The staff recognized that to respond to mental health problems (self-image, interpersonal relationships, school experiences, family roles, adolescent stress), the program's prevention efforts needed to be directed at a wide spectrum of community residents. The major thrust of the Youth Project continues to be the involvement of youth workers in public elementary and secondary schools. Youth are seen in groups that focus on the development of appropriate interactions.

625. Willner, M., Willner, F., & Mooney, E. (1976). The forgotten children: An agency does double duty. *Child Welfare, 55*, 423–430.

A foster care agency used its facilities in a preventive group-work program to assist black ghetto children and their families to counteract some aspects of racism and poverty. The living conditions created by poverty and racism serve to perpetuate their ghetto existence, and the children grow up with anger targeted at whites, their own peers, persons in authority, and even themselves. They are not allowed to express negative feelings about parents; thus, their anger must be directed at others or internalized. Many of the children had emotional or behavioral problems. The preventive and supportive program was developed to promote the social adjustment and development of children and youths from the ghetto and also to provide intensive supportive services to the children's families. Findings of a self-assessment procedure document show that the program is effective, with many children being motivated to do better in school, achieve better social relationships, and start to plan better for the future.

See also: 454, 458, 841, 898.

3. Hispanics

626. Delgado, M., & Montalro, S. 91979). Preventive mental health services for Hispanic preschool children. *Children Today, 8*, 6–8, 34.

A primary prevention community mental health program, focused on the needs of Hispanic preschool children, is discussed; and the consultation/intervention services provided to the children's parents, day care teachers, and family day care providers are described. The needs assessment study, which preceded implementation of the consultation program, and characteristics of the local Hispanic population are described. It is noted that Hispanic groups are no longer confined to large cities. The increase in demand for services by program staff is discussed in relation to the needs of young Hispanics.

627. **Gibson, G. (1978). An approach to identification and prevention of developmental difficulties among Mexican-American children.** ***American Journal of Orthopsychiatry, 48*****, 96-113.**

This paper reviews the relevant literature and discusses the nature of Chicano concerns in regard to the implementation of legislation mandating developmental assessment of poor children. An approach to providing screening and remedial services responsive to the needs of Mexican-Americans is outlined. (Author abstract) ©American Orthopsychiatric Association.

628. **Padilla, A.M., & Padilla, E.R. (1977).** ***Improving mental health and human services for Hispanic communities.*** **Washington, DC: COSSMHO.**

Selected papers from regional conferences in Los Angeles, California, and San Antonio, Texas, in 1975 on the topic of improving mental health and human services for Hispanic communities are presented. Chapters on the following topics are included: Chicanos and the nonsystem for mental health services, observations on the Chicano mental health movement, making psychiatry meaningful for Chicanos, measuring ethnicity among Mexican-Americans, alcoholism among Chicanos, principles of preventive mental health programs for Puerto Rican minority populations, preventive mental health strategies for the low-income Spanish speaking, a mental health research program for the Spanish speaking, and aspects of the legislative process relevant to better services delivery at the State and Federal levels.

629. **Valle, R., & Vega, W. (1980).** ***Hispanic natural support systems: Mental health promotion perspectives.*** **Sacramento, CA: California Department of Mental Health.**

Features of the natural support systems of Hispanic-Americans of Mexican descent are examined, along with the manner in which the systems are linked to wellness. A trimodel configuration of three primary subtypes is utilized in analyzing the networks/supports: (1) aggregate (group membership natural networks); (2) link/person (nongroup reciprocal relationship networks); and (3) kinship/familial, consanguineal networks. It is contended that understanding the dynamic processes of these networks within Hispanic cultures is crucial to developing culturally congruent mental health strategies. Emphasis is on the relationship between human service systems and Hispanic natural networks, and on the interaction among linguistic, cultural, and socioeconomic factors that affect the high-risk designation given to Hispanics. An overview of Hispanic mental health and health-related research and policy concerns is provided. Specific issues of cultural support and natural resource systems for Latino/Hispanic mental health are discussed. Mass media and other mental health promotional strategies for low-income Chicano/Mexicanos are examined, along with social mapping techniques and approaches for targeting at-risk populations.

See also: 898.

4. Others

630. **Bullough, B. (1972). Poverty, ethnic identity and prevention health care. *Journal of Health and Social Behavior, 13*, 347-359.**

Low-income mothers from three Los Angeles poverty areas, representing three ethnic groups, were questioned about the preventive health care they had obtained for themselves and their children. It was found that the more well-known barriers to the utilization of preventive services were reinforced by alienation, including feelings of powerlessness, hopelessness, and social isolation. Family planning behavior was found to be the type of preventive care most influenced by alienation. (Author abstract)

631. **Cohen, R.E. (1972). Principles of preventive mental health programs for ethnic minority populations: The acculturation of Puerto Ricans to the United States. *American Journal of Psychiatry, 128*,** 1529-1533.

Differences in value orientation cause serious adaptation problems in both Puerto Rican migrants and in the human and social institutions responsible for their education, employment, health, and recreation. The author discusses methods and techniques by which a mental health professional can intervene in this adaptation process and design mental health services in harmony with the value orientation of the population. Included among these methods are educational efforts around mental health principles, mental health manpower training with specific reference to problems of Puerto Ricans, participation and collaboration with existing agencies to sensitize them to the needs of Puerto Rican families, and consultations with other caregivers about how to help Puerto Ricans adjust in their new situation.

632. **Moritsugu, J., & Sue, S. (1983). Minority status as a stressor. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.),** ***Preventive psychology: Theory, research and practice*** (pp. 162–174). New York: Pergamon Press.

The epidemiological literature on minority status is reviewed, with discussions of research on minority status as a stressor, the theories of why it is a stressor, and the interventions directed at reducing the risk of dysfunction due to minority status. "Minority" is broadly defined as lack of membership in the prevailing social group within a perceived community. Factors contributing to stress, external and internal mediators of stress (i.e., resources in the environment and personal capacity to cope with stress), and ways in which preventive psychologists might intervene to prevent the ill effects of the stress of minority status on minority groups in organizations and communities are presented.

633. **Yee, T.T., & Lee, R.H. (1977). Based on cultural strengths, a school primary prevention program for Asian-American youth.** ***Community Mental Health Journal, 13*****, 239–248.**

A primary prevention program in schools is described that provides Asian-American youth with a positive view of their cultural identity and a supportive place to examine how their cultural values and behavior differ from those of mainstream Americans. The program served as a mental health component of a Filipino bilingual/cultural course encompassing two classes of 10th and 11th graders, and 11th and 12th graders. The program covered basic communication skills, self and identity, generational values, and the relationships of the self to society. Evaluation by students indicated that the program was valuable in teaching them more about themselves, their families, and where they stood in relation to their Filipino and American values. Guidelines for developing other bicultural primary prevention programs are offered.

See also: 90, 176, 205, 351, 500, 584, 743, 930.

B. Elderly

634. **American Institute for Research (1977). Senior actualization and growth explorations: A geriatric human potential program.** ***Innovations, 4*****,** 11–18.

Senior Actualization and Growth Explorations (SAGE), an innovative new program in geriatric preventive mental health services delivery in California, which relies heavily on techniques of the human potential movement, is described. First developed by Gay Luce, SAGE aims not only at providing a program that improves mental and physical health of the elderly but also at changing the current negative attitudes toward aging and the aged by emphasizing the Eastern philosophical tradition that associates aging with increased spiritual development. Techniques utilized in the program include: autogenic training and biofeedback; breathing exercises, yoga and meditation; guided imagery; Feldenkrais exercises; and Gestalt dream interpretation.

635. **Anderson, W.F. (1981). Is health education for the middle-aged and elderly a waste of time? *Family and Community Health, 3*, 1–10.**

Problems of chronic illness and the need for health care services among the elderly are examined. The relationship between physical, mental, and social health is discussed, along with the need for a comprehensive assessment in the home to insure accurate diagnosis. Preventive measures that should be advocated as part of public health education include exercise, nutrition, and provision of motivating factors to encourage positive mental health and attitude. Education and preretirement training are important, as is reemployment opportunities for retired persons. Continuity of care is also important in dealing with this age group, as is the proper instruction of physicians, health care workers, and nurses in geriatric medicine.

636. **Braceland, F.J. (1972). The mental hygiene of aging: Present day view. *Journal of the American Geriatric Society, 20*, 467–472.**

This article considers that the current trend toward rapid social change has engendered increased psychological stress for the elderly. Ways for maintaining mental health in old age are discussed. The author stresses that the emotional problems of the aged are the same as those in younger persons; there are no specific patterns after age 65. It is suggested that the preventive aspects of psychiatry should be increasingly stressed. ©APA.

637. **Braceland, F.J. (1977). Growing old and how to do it. *Psychiatric Annals, 7*, 4–10.**

The author discusses methods of prevention and management of emotional problems in the elderly. In teaching mental health hygiene to families, a middle ground between neglect and oversentimentality must be achieved. Failure in older people often stems from rejection of aging, envy of or resentment toward younger people, and materialistic selfishness. Major objectives should be maintenance of emotional security and personal dignity, tolerance, and active assistance in mitigating feelings of social loss, uselessness, and desolation. ©APA.

638. **Coe, R.M. (1983). Assessment of preventive health practices for the aged. *Gerontologist, 13*, 345–348.**

The author suggests that a broadening of preventive practices for elderly persons to include "health maintenance" is necessary if programs are to be successful. Some of the main characteristics of such a comprehensive health care system are identified.

639. **Douglass, R.L. (1983). Opportunities for prevention of domestic neglect and abuse of the elderly. *Prevention in Human Services, 3*, 135–150.**

Recent research has demonstrated that domestic neglect and abuse of the elderly is not uncommon in the United States. It is a social problem that has not been extensively researched, however. One of the few studies, conducted in Michigan, found that the oldest and most frail elderly were a target group of elevated risk. Victims of neglect or abuse tend to be living with adult children or other informal caretakers who become neglectful or abusive when the burdens of providing care for a frail, elderly person interact with stress, little or no preparation for providing personal care over a long time span, medical problems of the caretaker, alcohol abuse, financial difficulties, and other situational factors. Family histories of neglect or abuse and other causal hypotheses have also been investigated. Recent studies are reviewed and found to be in general agreement regarding the nature and apparent dynamics of this emerging problem among the elderly. Opportunities for prevention are discussed in terms of current models of service to the aging and redirection of other public health and social services. (Author abstract) ©The Haworth Press.

640. **Finkel, S.I., & Cohen, G. (1982). The mental health of the aging. *Gerontologist, 22*, 227–228.**

This article reviews the recent establishment of government and private task forces and studies on aging and makes recommendations to the 1982 United Nations World Assemtly on Aging. These recommendations include increased economic aid for mental health problems, research on aging that would emphasize the prevention of psychiatric illnesses in the elderly, and research aimed at improving the capacity of families and social support systems to be more effective in preventing inappropriate institutionalization of the elderly. ©APA.

641. **France, M.H., & McDowell, C. (1982). Seniors helping seniors: A model of peer counselling for the aged.** ***Canada's Mental Health*, 30, 13–15.**

The authors describe a model for training senior citizens as peer counselors in an outreach and self-help program. The focus is on increasing preventive mental health services for the elderly. ©APA.

642. **Harris, R. (1974). The role of physical activity in preventing mental illness among the aging.** ***American Journal of Orthopsychiatry*, 44, 261–262.**

The article discusses proper physical activity and physical fitness as a contribution to good mental health and the prevention of mental illness in old age. Effective patterns of physical activity and fitness established during youth and middle age and followed in old age provide a structured time relationship for older people that helps them to cope with the potentially threatening environment and reduces and retards the changes of the aging process. Even begun in old age, physical activity patterns and programs also promote greater mobility, socialization, and participation with other people. Aging patients with organic brain disease, senile dementia, and other cerebral vascular disease may benefit from participation in such programs. (Author abstract modified)

643. **Hirschowitz, R.G. (1973). Foster Grandparents Program: Preventive intervention with the elderly poor.** ***Hospital & Community Psychiatry*, 24, 558–559.**

Citing varied social conditions that place the elderly poor at risk for both physical and psychological dysfunction, the author stresses the usefulness of designing prevention interventions with this population to strengthen their independence and productivity. The author then describes an example of one such intervention, a foster grandparents program, Federally funded, which allows low-income people over 60 to work with needy children, many of whom are institutionalized. Various aspects of the program are then described, including recruitment procedures and the inducements offered to the elderly for their participation. Reports of the participating grandparents show tangible benefit, both from working with the children and from being part of the larger group of grandparents. The author concludes that the aged poor are employable and can be a resource as service providers.

644. **Jellinek, T., & Tennstedt, S.L. (1980). Prevention of chronicity in the nursing home.** *Psychiatric Annals, 10,* 37–38.

The experiences of one mental health center in providing treatment and mental health consultation services to nursing homes, with a major goal of prevention of chronicity, are described. The nursing home environment is discussed as it affects the processes of adaptation to losses in the elderly in the biological, social, and psychological spheres. In view of the importance of environmental factors, including staff roles and relationships, major program goals included education of staffs on mental health needs of residents, alteration of the nursing home milieu to meet these needs, and provision of direct clinical services to residents needing specialized treatment. Client-centered and consultee-centered case consultations were provided, staff development programs were offered, and administrative consultations were undertaken. Illustrative case consultations involving lack of motivation, increasing disorientation, and auditory hallucinations are presented.

645. **Kral, V.A. (1968). In geriatric psychiatry. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders* (pp. 129–139). Toronto: University of Toronto Press.**

Summarizing studies of diagnoses, the author concludes that senile and arteriosclerotic psychoses account for only 25–30 percent of mental disorders among the aged. Very common among elderly people are neurotic reactions to the social and biological facts of aging, which may arouse considerable anxiety. Prevention of such neuroses is dependent upon a change in society's attitude toward the aged, so that they are no longer viewed as useless and infirm. Another disorder of the aged, confusional states, may be prevented through the avoidance of acute stress. This may also be helpful in the prevention of the functional psychoses. Senile and arteriosclerotic psychoses may be prevented as more information is accumulated on metabolic disorder, and by the avoidance of stress. The author reports findings of a study of 112 persons with a mean age of 81. It was found that subjects experiencing emotional insecurity as children developed organic brain disorders in old age significantly more frequently than those with emotionally secure experiences as children. Also, those subjects who later developed organic disorders were significantly less adaptable in stress situations throughout their lives.

646. Lesse, S. (1973). Future oriented psychotherapy as a prophylactic gerontological procedure. *American Journal of Psychotherapy, 27*, 166–177.

The author contends that it is not realistic, either socially or economically, for psychiatric techniques to be utilized solely in a curative role. Their prophylactic, preventive function must be recognized. A wide range of populations have been found amenable to future-oriented psychotherapy. Specific techniques in handling clients 65 years of age or older are discussed.

647. Lombana, J.H. (1976). Counseling the elderly: Remediation plus prevention. *Personnel and Guidance Journal, 55*, 143–144.

Remedial and preventive counseling can assist the elderly in becoming productive, independent members of society. In the remedial area, the elderly need personal counseling for those with serious mental health concerns, supportive counseling for those with serious physical health problems, motivation and adjustment counseling for those residing in or leaving residential institutions, and avocational counseling and retraining. In the area of preventive guidance, public policies need to be developed in several areas, including preretirement counseling, lifelong health education, avocational opportunities and leisure activities, programs of information regarding available services, educational and recreational opportunities, and education of the general public to dispel stereotypes of the aged.

648. Lowy, L. (1983). Social policies and programs for the elderly as mechanisms of prevention. *Prevention in Human Services, 3*, 7–21.

The concept of prevention is defined and the role of social policy as a primary prevention mechanism is explored. Common programs for the elderly and their strengths and limitations are described. Recommendations are made for new social policies, based on the philosophy of prevention, that are comprehensive, flexible, responsive, and informed by the elderly themselves. (Author abstract) ©The Haworth Press.

649. Miller, J.R. (1981). Family support of the elderly. *Family and Community Health, 3*, 39–49.

The role of family support in promoting health and preventing disease in the elderly is examined to refute arguments that the aged in American society are alienated from their kin. There is some question, however, of the quality of family relations among the elderly and younger generations. Major psychosocial problems that threaten multigenerational families include: disengagement, enmeshment, infantilization, parentification, and scapegoating. Families with difficulties in these areas are seen as benefiting from professional assistance from a variety of health care programs in order to enforce preventive health behavior and assist members in coping with health problems and life changes. Such assistance is particularly important in families with low incomes, geographically distant elderly members, and employed middle-aged women. Nutrition sites, senior centers, senior organizations, churches, and voluntary organizations can augment professional agencies in this service area.

650. Morrison, J.D. (1980). Geriatric preventive health maintenance. *Journal of the American Geriatrics Society, 28,* 133–135.

A preventive approach to geriatric health care that includes periodic and systematic assessment of the physical, mental, and social status of the elderly person is proposed. Important aspects of geriatric health maintenance are identified, including the need for a social/mental/emotional approach that considers the risks of social isolation, the high incidence of depression and organic brain syndrome, and the potential for physical deterioration through poor nutrition, lack of exercise, poor compliance with medication schedules, and general neglect. Primary prevention in the social and emotional spheres involves anticipatory guidance for such issues as retirement, finances, living situation, sex, the meaning of life, bereavement, and death.

651. Nickoley-Colquitt, S. (1981). Preventive group interventions for elderly clients: Are they effective? *Family and Community Health, 3,* 67–85.

The effectiveness of group intervention strategies for promoting the health of elderly clients is examined, emphasizing their appropriateness in view of changing views on health care and the expansion of services from institutional to community settings. Types of groups that may prove useful in this area include: socialization, competency, and problem-solving groups; support and age integrated, life crisis groups; well-being, encounter, and here and now groups; senior actualization and growth exploration groups; interpersonal skill training; expressive psychotherapy; and resocialization groups. The needs which these approaches address include: stress, health maintenance and disease prevention, education and support in mobilizing psychological resources, sharing of tasks, cognitive guidance in handling life crises, and promoting a sense of personal responsibility and self-control.

652. **Pilisuk, M., & Minkler, M. (1980). Supportive networks: Life ties for the elderly. *Journal of Social Issues, 36,* 95–116.**

The ways in which a variety of programs provide social support to the elderly are explored. Six different programs are examined to illustrate the importance of attention to health status, ethnicity, and lifestyle in the provison of social supports. By evaluating the offerings of these programs against the concept of network theory, it is shown that the needs for social support among the elderly are highly differentiated and deserving of equally differentiated forms of response. As persons particularly vulnerable to stressful social losses such as the death of family members, retirement, and geographic moves, older Americans seem to constitute a group for whom intentional, extrakinship network development may play an increasingly important role in health maintenance. (Author abstract modified)

653. **Quam, J.K. (1984). Older women and informal supports: Impact on prevention. *Prevention in Human Services, 3,* 119–133.**

This paper briefly reviews the literature about friendship as an informal support for older women, an at-risk population whose numbers are increasing. Data from an AOA-supported study indicate that older women use their friends differentially depending both on the nature and qualities of the friendship and the type of help that is required. Friends are more likely to provide help with social-emotional tasks than instrumental ones. Programs should be designed that maximize interaction among older women and those who would serve as informal supports. (Author abstract) üThe Haworth Press.

654. **Schaie, K.W. (1981). Psychological changes from midlife to early old age: Implications for the maintenance of mental health. *American Journal of Orthopsychiatry, 51,* 199–218.**

The author describes changes from midlife to old age and discusses conceptual models of adult development to debunk some commonly held stereotypes. Effects of biological change on behavior; age differences in learning, memory, and motivation; and age changes in intelligence and personality are considered, including implications for primary prevention, diagnosis, and social intervention. üAPA.

655. **Smyer, M.A., Davis, B.W., & Cohn, M. (1982). A prevention approach to critical life events of the elderly.** *Journal of Primary Prevention, 2*, 195–204.

Professionals interested in aging and mental health have not fully considered possibilities for prevention of psychological distress in the elderly. This article presents a conceptual framework and rationale for developing preventive interventions focused on older adults. An example is presented of a project designed as an educative intervention anticipating stressful events associated with the changing interdependencies of families in later life. The project sought to reinforce the role of the family as an informal support system for rural adults in their middle and later years. A series of six pamphlets was developed to focus on common problems faced by families during the second half of life.

656. **Spivack, G. (1982). Interpersonal problem-solving thought: Mental health promotion for the elderly. In F.D. Perlmutter (Ed.),** ***New directions for mental health services: Mental health promotion and primary prevention*** **(pp. 87–90). San Francisco: Jossey-Bass.**

A theory that explains why interpersonal relationships deteriorate with old age among some individuals and not among others is proposed, and programming that can prevent such deterioration is described. The theory proposes that interpersonal, cognitive problem-solving skills (ICPS) mediate the quality of social relationships throughout the lifespan. These social cognitive skills define the efficiency with which individuals think through typical, interpersonal problems, such as making friends, dealing with conflicts, and expressing negative feelings. If results of initial studies are confirmed and the specific, crucial ICPS skills are pinpointed in the elderly, preventive work would have a theoretical base and specific guidelines for preventive programming. Mental health promotion activity could be conducted in a variety of settings that house the elderly. After identification of trainable social cognitive skills, steps could be taken to enhance these skills and promote social adjustment among the elderly.

657. York, J. (1976). CMHC consultation aids nursing homes. *Innovations, 3*, 37–38.

A preventive-oriented consultation and training program for staff members of geriatric nursing homes in Lansing, Michigan, is believed to be responsible for a reduction of nursing home patient admissions to State hospitals and community mental health units. The training team consists of a psychologist coordinator, a psychiatric nurse, an occupational therapist, and a part-time psychiatric resident. Activities include individual patient consultations, staff training, and the development of core groups among nursing home staff who implement action programs. Training topics are discussed, and innovative programs initiated by core groups are described.

See also: 88, 229, 497, 849, 857.

C. Other Populations

658. Ablon, J. (1982). The Parents' Auxiliary of Little People of America: A self-help model of social support for families of short-statured children. *Prevention in Human Services, 1*, 31–46.

Average-sized parents of newborn and young dwarf children characteristically experience emotional distress growing out of a lack of knowledge about the practical and social problems their child will experience. The Parents' Auxiliary of Little People of America provides information and advice that enables parents to deal successfully with the medical and logistical problems of child-rearing and their short-statured child's development. It further offers social and psychological support that legitimizes self-image for dwarfs and their families and provides role models of happy, effectively functioning adult dwarfs and children who have made successful adaptations to the average-sized world around them. (Author abstract) ©The Haworth Press.

659. Altschuler, K.Z. (1974). The social and psychological development of the deaf child: Problems, their treatment and prevention. *American Annals of the Deaf, 119*, 365–376.

The normal tasks of growth are discussed, including differentiation of the self from the rest of the world, the development of reciprocal relationships with others, and the translation of external restraints into a system of automatic internalized controls. Evolution of these functions rests on a maturational timetable whereby increasing cognitive, intellectual, and motor capacities come into play at age-specific times. The pathways involved in normal development and how they may be interefered with by the absence of audition and by family responses in the case of a deaf child are described. Behavioral problems, problems of family, and difficulties of motivation versus capacity that may occur, as well as the occasional, more severe, gradations of illness are defined. From the standpoint of the normal developmental tracks, preventive suggestions are offered that can aid the deaf child in his growth toward health. (Author abstract modified)

660. **Irvine, E.E. (1974). The risks of the register: On the management of expectation. In E. Anthony (Ed.),** ***The child in his family, Vol. 3.*** (pp. 181–191). New York: **Wiley.**

Parental attitudes and behaviors as important factors in the development or prevention of psychiatric disturbance in handicapped children are examined. Disappointment, grief, resentment, anxiety, and guilt are normal expectable reactions to severe handicap and are liable to give rise to dysfunctional defenses. The need to encourage parents of handicapped children to help them in their adjustment, to preserve their morale, and to recognize them as partners in the preventive enterprise is stressed. Two considerations are important: (1) if the parents' potential for helping the child to develop competence and master the handicap is mobilized, they will have more to give the child than any therapist; (2) it is vital for the parents' own stability to be given a method for helping the child overcome the handicap.

661. **Schlesinger, H.S., & Meadow, K.P. (1972). A conceptual model for a program of community psychiatry for a deaf population.** ***Community Mental Health Journal, 8,*** **47–59.**

A conceptual model for the development of a comprehensive program of community psychiatry for a deaf population is presented, with illustrations from a program currently under way at the Langley Porter Neuropsychiatric Institute in San Francisco. The model has worked well with this special population, bound together by a common communicative mode, common educational experiences, and similar problems of living. The model stresses primary prevention of mental disorders in addition to providing secondary and tertiary prevention and treatment. Eight ingredients of the comprehensive program include: clinical or therapeutic services for individuals and families, collaboration with other agencies, mental health consultation, research, community organization, public education, administration, and staff development. The deaf patient, the deaf community, and the response of the hearing community to deafness all present problems for the mental health practitioner that are in some ways unique. The model presented here is one approach for dealing with the unusual and interesting aspects of these problems. (Author abstract) ©Human Sciences Press.

X. Primary Prevention of Specific Mental Disorders

Most articles involving primary prevention of psychopathology do not address the prevention of any one specific disorder. Articles within this category are those that do, however, discuss the prevention of a specific mental disorder. Articles have been subdivided according to those pertaining to the prevention of schizophrenia, the prevention of depression, and the prevention of other mental disorders.

A. Schizophrenia

662. **Asarnow, R., & Asarnow, J.R. (1982). Attention-information processing dysfunction and vulnerability to schizophrenia: Implications for preventive intervention. In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready*? (pp. 90–113). (DHHS Pub. No. (ADM) 82–1111). Washington, DC: U. S. Government Printing Office.**

A transactional model of schizophrenia is presented whereby the manifestations of vulnerability to schizophrenia are thought to vary at different developmental phases, reflecting both maturational effects on these earlier processes as well as the way these processes have been modified by environmental transactions. Findings from the Master-Waterloo Project are presented that indicate the presence of attention/information dysfunction is more predominant in children who are at high risk for schizophrenia than in normals. Implications for preventive intervention research are discussed.

663. **Friedhoff, A.J. (1982). Can biological risk be measured? Altered? In M.J. Goldstein (Ed.), *Preventive intervention in schizophrenia: Are we ready*? (pp. 39–51). (DHHS Pub. No. (ADM) 82–1111). Washington, DC: U.S. Government Printing Office.**

The current status of biochemical markers derived from research contrasting schizophrenic persons with normal controls is examined. Possible biochemical markers discussed include dopamine, norepinephrine, serotonin, and platetet monoamine oxidase. Evidence for the possible prevention of schizophrenia by exposure to dopamine receptor blocking and antipsychotic drugs during fetal development is presented along with cautions regarding the possible adverse effects of such an approach.

664. **Leonhard, K. (1978). Can schizophrenia be prevented? Empirical results obtained by the examination of schizophrenic twins and schizophrenic children.** ***International Journal of Social Psychiatry, 25,*** **285–294.**

This paper describes research on schizophrenia in twins and children that, according to the author, supports the belief that "the problem should be considered within the context of cultural factors" and hence psychosocially preventable. Clinical examination of persons who, at the onset of the illness, were under age 15 suggested that deficiency of communication and stimulation in childhood was a common factor. The author distinguishes between periodic catatonia and mobility psychosis as being of different origins. In summary, the findings suggest that isolation can provoke schizophrenia, but the impact of preventive efforts through preventing isolation would seemingly have a more positive impact on insidiously progressive schizophrenia than on psychoses running a phasic course.

665. **Rolf, J.E., & Harig, P.T. (1974). Etiological research in schizophrenia and the rationale for primary intervention.** ***American Journal of Orthopsychiatry, 44,*** **538–554.**

The theories, method types, and general findings of etiological research in schizophrenia and the primary prevention literature are briefly reviewed. New directions in the developmental studies of high-risk children and the rationale for the inclusion of controlled primary prevention treatments are discussed.

See also: 90, 323, 328, 334, 347, 348, 354, 358, 359, 361, 363, 367, 382, 383, 391, 668, 670, 675.

B. Depression

666. **Jacobson, A. (1980). Melancholy in the 20th century: Causes and prevention.** ***Journal of Psychiatric Nursing and Mental Health Services, 18,*** **11–21.**

The detrimental aspects of depression and melancholy for both individuals and society are examined. The epidemiology and causes of depression are reviewed. In order to deal with depression, a plan for a preventive community health program is proposed. Although all three levels of prevention are considered, primary prevention is emphasized, using support networks and anticipatory guidance for a high-risk population during critical developmental states. The self-care concept articulated by Orem is used as a framework for nursing's involvement in the problem.

667. **Munoz, R.F., Glish, M., Soo-Hoo, T., & Roberston, J. (1982). The San Francisco mood survey project: Preliminary work toward the prevention of depression.** ***American Journal of Community Psychology, 10,*** **317-329.**

A framework for the adaptation of social learning, cognitive-behavioral treatment approaches to prevention of depression is described. In addition, an illustrative example is given of a survey study that measured behavior and mood before and after a 2-week television miniseries based on these approaches. Three of 14 behaviors showed a significant change. Mood level improved significantly more for an originally symptomatic group that watched the segments when compared to a similarly symptomatic group that did not watch them. Implications of the study for future work are delineated. (Author abstract) ©Plenum Publishing Corp.

See also: 90.

C. Others

668. **Ban, T.A., Vartanian, F.E., Sartorius, N., & Jablinsky, A. (1979). Identification of high-risk criteria in the framework of W.H.O. collaborative research in the major mental disorders.** ***Progress in Neuro-Psychopharmacology, 3,*** **575-578.**

The primary prevention of psychiatric disorders is discussed in terms of World Health Organization (WHO) efforts to identify high-risk criteria for psychiatric disorders. It is emphasized that malnutrition and infection-induced secondary mental deficiencies are still prevalent in the developing nations. Relevant WHO projects are reviewed. The following topics are discussed: mental deficiencies, Down's syndrome, amniocentesis, malnutrition, infections, and schizophrenia. (Author abstract modified)

669. **Barrios, B.A., & Shigetomi, C.C. (1980). Coping skills training: Potential for prevention of fears and anxieties.** ***Behavior Therapy, 11,*** **431-439.**

Coping techniques that teach the individual an active skill for dealing with a variety of anxiety-provoking situations may be an effective method of preventing fears and anxiety reactions. Outcome data in general indicate the effectiveness of such procedures in the treatment of fears. An examination of the epidemiological data on fears and anxieties and the characteristics of coping skills training indicate the preventive potential of coping skills procedures. A "milestone" approach (i.e., working with groups of people about to undergo stress-related changes in their lives such as marriage, starting school, or retirement) is recommended. ©APA.

670. **Eisenberg, L. (1975). Primary prevention and early detection in mental illness. *Bulletin of the New York Academy of Medicine, 51*, 118–129.**

The general principles in the prevention of three major psychiatric syndromes that greatly affect the public health--schizophrenia, affective disorders, and developmental attrition syndromes--are discussed. There is persuasive evidence that appropriate treatment at the onset of acute psychosis can markedly influence its outcome, foreshortening the duration of the acute episode and providing a greater likelihood for the resumption of a productive life. The treatment and prevention of schizophrenias has been aided by the rediscovery of open hospitals and community care in addition to the introduction of new neuroleptic drugs (phenothiazines, thioxanthenes, and butyrophenones). Many patients can be managed on an outpatient basis. The affective disorders, mania and depression, can now be successfully treated with both antidepressants and lithium. There is strong evidence that maintenance lithium therapy markedly reduces the recurrence rate in such affective disorders. There is potential for primary prevention of developmental attrition syndromes through programs designed to preserve the integrity of the family when it is salvageable, to provide effective foster and group care, and to insure adoption when the family of origin no longer exists or is clearly pathological.

671. **Groen, J.J. (1974). The challenge of the future: The prevention of psychosomatic disorders. *Psychotherapy and Psychosomatics, 23*, 283–303.**

The author advocates preventive trials based on the hypothesis that psychosomatic diseases are caused by frustrations induced in some people during their communication with key figures in the family and in work groups to which they belong. The prevention of psychosomatic diseases should be directed at (a) improvement of education and personality formation, (b) improvement of human communication, and (c) recognition of precursors and early signs of psychosomatic disease. ©APA.

672. **Hunter, R.C.A. (1968). Primary prevention of specific disorders: Neurotic states. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders* (pp. 98–110). Toronto: University of Toronto Press.**

Primary prevention of neurotic disorders is dependent upon adequate knowledge of the etiology of neurosis. The author discusses findings from animal, child development, and epidemiological studies. Animal studies must be interpreted cautiously, but do indicate that interference with growth or development, deprivation of nurture or phase-specific developmental stimuli, learning experiences that overtax discriminatory ability, social manipulation, or the deliberate evocation of fear responses may lead to aberrant functioning. Child development studies implicate problems of pregnancy and childbirth, infants' congenital-activity types, breakdowns in mothering related to various maternal or family problems, learning of maladaptive responses, the influence of crisis situations, problems at different psychosexual stages of development, and difficulties in the process of ego growth and maturation. The most significant finding of epidemiological studies is the association between low socioeconomic status and a high incidence of psychopathology.

673. **Levi, L. (1980). Prevention of stress-related disorders on a population scale. *International Journal of Mental Health*, *9*, 9–26.**

Problems in preventing stress-related disorders among the Swedish population are addressed, and proposed guidelines are presented. It is contended that health and well-being depend on the complicated interplay between people and their environment, and that prevention must focus on a multiplicity of factors and events. Planning of services must be participatory, coordinated, integrated, continuous, and constantly evaluated. A holistic, ecological, and systems approach is proposed. The approach emphasizes learning from experience via feedback and evaluation; democratization and activation; individualization; use of existing knowledge and technology; integrated monitoring of environment, health, and well-being; the acquisition of new knowledge; and research on psychosocial factors at the community level.

674. **Levi, L., & Kagan, A. (1971). A synopsis of ecology and psychiatry: Some theoretical psychosomatic considerations, review of some studies, and discussion of preventive aspects. *Excerpta Medica International Congress Series*, *274*, 369–379.**

The author discusses ecology and psychiatry, focusing on theoretical, etiological, and pathogenetic aspects of psychosomatic disorders, illustrating these aspects with data from recent studies, and presenting some viewpoints on prevention. Sustained stress contributes to clinically manifest symptoms, and the question of subsequent permanent structural damage is explored. A theoretical model of psychosocially mediated disease is discussed, and principles of monitoring, prevention, and research are outlined. ©APA.

675. **Mednick, S.A., Baert, A.E., & Bachmann, B.P. (1981). *Prospective longitudinal research: An empirical basis for the primary prevention of psychosocial disorders*. New York: Oxford University Press.**

Longitudinal prospective research, an important tool in the understanding of the bases of chronic psychosocial disorders, is examined. It is shown that longitudinal prospective research projects are delicate, long-term enterprises that have special scientific, administrative, and financial needs. As many longitudinal prospective studies in the European Region of the World Health Organization as possible were traced and located. The projects vary widely in complexity and scope: some have been undertaken by experienced researchers assisted by large research teams, and others were undertaken by individual investigators. All groups maintained contact with their study cohorts despite financial and professional difficulties. The studies cover: (1) normal, representative populations; (2) nonrepresentative populations (twin, adoptee, first cousin, birth difficulty, and neonatal brain damage); and (3) followup studies of deviant groups.

676. **Poser, E.G. (1970). Toward a theory of "Behavioral Prophylaxis," *Journal of Behavioral Therapy and Experimental Psychiatry*, *1*, 39–43.**

On the basis of studies investigating the effect of preexposure and past experience on subsequent stress tolerance, it is suggested that current techniques of behavior modification may be applicable to primary prevention in the mental health field. Animal laboratory studies and human clinical studies are cited in support of this contention. Specific examples are given illustrating the application of learning techniques to the prevention of disorders such as separation anxiety, stage fright, and addictive and obsessive behavior. (Author abstract)

677. **Poser, E.G., & King, M.C. (1976). Primary prevention of fear: An experimental approach. In I.G. Sarason, & C.D. Spielberger (Eds.), *Stress and anxiety: III* (pp. 325–344). New York: Hemisphere.**

The authors evaluate various approaches to primary prevention of behavioral disorders on the basis of experimental psychology and learning theory. Topics discussed include (a) detecting populations at psychological risk, (b) alternative approaches to prevention (systematic desensitization, coping techniques, and learned helplessness), (c) emerging principles of preventive anxiety reduction, and (d) future prospects of behavioral prevention. ©APA.

678. **Salk, L. (1968). On the prevention of schizophrenia. *Diseases of the Nervous System, 19*, 11-16.**

The author's interest in this paper is in the prevention of early infantile autism. After reviewing research on the effects of early sensory and maternal deprivation on animals, suggestions are made for how this knowledge could be applied to prevent autism. First of all, this knowledge must be transmitted to the obstetrician and pediatrician. Consultation to parents on the importance of early sensory stimulation should be available to all expectant couples. Finally, it is stressed that hospital procedures, routines, and facilities dealing with newborns and their mothers should be arranged to facilitate the conditions that maintain and enhance the mother-infant relationship during this critical period.

XI. Crisis Intervention as a Primary Prevention Strategy

Crisis intervention can be one type of primary prevention strategy. Usually, the major aim is to intervene with individuals who have experienced a crisis or traumatic event in various ways such that long-term psychological problems resulting from the incident can be avoided. Articles in this section are similar in many respects to the next section of articles having to do with primary prevention following stressful life events. Articles in which the author(s) have conceptualized their work as involving "crisis intervention" are grouped in this section. A common feature of many crisis intervention prevention programs is that they are usually set up to handle a variety of different yet predictable crises that individuals may experience. In the articles in this section, the exact reason for the the crisis an individual may experience is varied or unspecified, whereas in the next section, the nature of the stressful life event is specified, e.g., divorce, death of family member, etc. Thus, as defined in this bibliography, crisis intervention is primarily a person-centered strategy, whereas stressful life events focus on event-centered interventions.

Articles in this section are grouped into three categories. The first includes articles that provide reviews and/or conceptual discussions of crisis intervention preventive research. The second includes articles that describe preventive programs for individuals or families who are undergoing a crisis of some sort. The nature of the crisis is often varied and not shared on a greater community level. Finally, articles in the last section describe preventive interventions following crises experienced systemwide by a population of individuals. Such crises were the result of some sort of large-scale calamity or natural disaster.

A. Reviews and Conceptual Discussions

679. **Auerbach, S.M., & Kilmann, P.R. (1977). Crisis intervention: A review of outcome research. *Psychological Bulletin, 84*, 1189-1217.**

Crisis intervention studies conducted in suicide prevention/crisis intervention programs, in psychiatric settings, and with surgical patients, are critically evaluated. In the first area, the impracticality of suicide as an outcome measure and the need for shifting evaluation emphasis from crisis worker performance to client behavior change measures is emphasized. Also, the virtual impossibility of demonstrating overall program impact on the community and the need for developing overall program impact procedures is noted. Studies in psychiatric settings suffer from considerable methodological shortcomings that prohibit definitive conclusions; studies operationally specifying treatment components are greatly needed here. Studies with surgery patients indicate the necessity for developing intervention techniques most appropriate for individuals who differ in their typical manner of dealing with stress. In all settings, outcome measures should be appropriate to the situation and logically related to the goals of intervention.

680. **Bolman, W.M., & Bolman, G.C. (1979). Crisis intervention as primary or secondary prevention. In I.N. Berlin, & L.A. Stone (Eds.), *Basic Handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 225-254). New York: Basic Books.**

The article reviews crisis intervention prevention research and programs. Crisis theory is briefly reviewed and critiqued and is followed with a typology of various biomedical and psychosocial crisis intervention prevention programs. The authors then proceed to discuss and illustrate various types of crisis intervention that have been implemented for specific populations or specific types of crises or stressful life events. The first type to be discussed is prevention programs for newborns, infants, and their parents. Such programs include intervening with families upon birth of their new infant, parent education programs, the prevention of perinatal injury, and the promotion of mother-infant bonding. Intervention with children of psychotic parents is then examined, followed by discussions of day care programs, Head Start, and EPSDT (early periodic screening, diagnosis, treatment) efforts. The authors also discuss child abuse prevention as well as intervention with children undergoing certain situational or developmental crises such as illness, hospitalization, or school entry. Finally, work with adolescent populations undergoing certain crises such as unwanted pregnancy, running away, or criminal activity is looked at, and a table listing the range of theoretically possible prevention programs for adolescents is given.

681. **Bructon, M. (1975). The crippled tree and the fair blossom: Critical early intervention in family life. *Child Psychiatry Quarterly, 8*, 9–12.**

The author discusses the emerging question of crisis intervention and preventive psychology. Conditions in a Welsh psychiatric hospital are described. The primary treatment mode, crisis intervention, appears to offer short-term gains. A model of preventive psychology is presented that is family-centered and can be used in conjunction with the traditional crisis intervention modality. ©APA.

682. **Klein, D.C., & Lindemann, E. (1961). Preventive intervention in individual and family crisis situations. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 283–306). New York: Basic Books.**

This article describes the work of a multidisciplinary team that investigated, in a series of interrelated projects, the thesis that crises allow for the expression of both adaptive and maladaptive responses, each of which carries implications for future ability to cope. A framework for the design and implementation of preventive interventions is outlined; it centers on the concepts of the emotionally hazardous situation, crisis, and emotional predicament. Clinical services for a predicament-based service are described and include such steps as appraisal of the predicament, planning the nature of the intervention, altering the balance of forces to restore personal equilibrium, resolving the crisis, and developing the ability to anticipate possible future crises. An example of this general approach with student nurses as they face the initial stress of being on the job is described as is a preventive intervention involving a preschool checkup service.

683. **Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry, 101*, 141–148.**

The author states and elaborates on four points: (1) Acute grief is a definite syndrome with psychological and somatic symptomatology. (2) This syndrome may appear immediately after a crisis; it may be delayed; it may be exaggerated or apparently absent. (3) In place of the typical syndrome there may appear distorted pictures, each of which represents one special aspect of the grief syndrome. (4) By use of appropriate techniques, these distorted pictures can be successfully transformed into a normal grief reaction with resolution. Based on a sample of 101 patients, the symptomatology of normal grief is described and the course of normal grief reactions documented. Various kinds of grief reactions are detailed, and their psychiatric management outlined. The importance of prophylactic measures (preventive steps) is highlighted.

684. **Malone, C.A. (1979). Crisis intervention as primary or secondary prevention with poverty parents at risk. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 284-291). New York: Basic Books.**

The author cites the adverse effects of poverty as placing poor parents at risk for the development of psychopathology. Preventive intervention, centered around a crisis intervention approach to stressful life events, is particularly needed with this population. Suggestions for how mental health professionals should approach their work in impoverished settings with low-income individuals are given. It is argued that preventive services need to be linked with epidemiological studies that have identified hazardous situations for the mental health of low-income parents. These services should aim at an identifiable target population; be decentralized in convenient neighborhood locations; and be linked with existing community health, mental health, and educational services in order to facilitate collaborative work. Preventive services should be tied to known life stressors such as loss of job, eviction from home, periods when vital physical supplies are lacking, death or illness of a family member, and others. It is stated that preventive services need to extend their focus beyond the individual to include the individual's family, social network, and the parents' longer-term psychosocial needs. A restructuring of social service agencies to function more in coordination with one another would help in the formation of crisis intervention teams that could function in a preventive role. Finally, day care services, family planning services, perinatal services, and family and pediatric health care are all discussed with regard to the important prevention role they can provide for impoverished parents.

685. **McGee, R.K. (1974). *Crisis intervention in the community*. Baltimore: University Park Press.**

Crisis intervention in the community is traced historically and thematically in the U.S. The development of crisis intervention centers is described in detail through observations and self-study, and 10 such systems in the southeastern United States, many manned by volunteers delivering telephone service in suicide prevention programs, are evaluated. The central theme of such centers represents constructive community action. A model is proposed for developing new programs to utilize the concerns and resources of a community for crisis intervention, from legitimization and sponsorship to operation. Criteria for evaluation of programs and operational concepts and guidelines are suggested.

686. **Parad, H., & Caplan, G. (1965). A framework for studying families in crisis. In H.J. Parad (Ed.), *Crisis intervention: Selected readings* (pp. 53–72). New York: Families Service Association of America.**

This paper outlines a theoretical framework for studying families in crisis and the relationship of family functioning to mental health. This conceptual framework evolved from a study of mental health functions within a public health setting, utilizing interviews with families in crisis. From this data they developed the framework, which included a definition of crisis and family homeostasis. A case example illustrates how this model is used with a family in crisis and offers a method to evaluate the need for the appropriate forms of preventive intervention during crisis.

687. **Pasewark, R.A., & Albers, D.A. (1972). Crisis intervention: Theory in search of a program. *Social Work, 17*, 70–77.**

Crisis intervention, practiced effectively in the public health field, is explored in its implications for use in mental health and the helping services. Developed over a period of years, largely through the work of Erickson, Lindemann, and Caplan, crisis intervention seeks to provide an individual with appropriate behavioral patterns that will enable him to deal effectively with the specific crisis. It has three phases: (1) Primary Prevention--the incidence of a disorder is reduced by altering the environment so that it restrains the disease process or makes the individual less susceptible; (2) Secondary Prevention--a mild disorder is kept from becoming a severe one; (3) Tertiary Prevention--serious disorder is restrained from producing permanent disability. There is a notable absence of programs either totally or primarily oriented toward the crisis intervention approach. The reasons include: (1) lack of financial commitment and personnel, (2) risk involved in adoption of the method due to its unsubstantiated effectiveness, (3) abrupt adjustment by mental health workers required to produce an effective model, and (4) the questions that adoption of crisis intervention would raise regarding the use of the current community mental health center model.

688. **Schulberg, H.C., & Sheldon, A. (1968). The probability of crisis and strategies for preventive intervention. *Archives of General Psychiatry, 18,* 553–558.**

The authors state that the concept of crisis continues to serve as a prime rationale for programs of preventive intervention, and it is necessary, therefore, to refine its parameters so as to enhance our selection of appropriate strategies. A major gap in earlier conceptualizations of crisis has been the failure to specify the association between risk and personal reactions. A probability formulation of crisis is proposed based upon three factors: the probability that a hazardous event will occur; the probability that an individual will be exposed to this event; and the individual's vulnerability to this event. Based upon this formulation, strategies for intervention can be selected according to the predictability and frequency of the hazardous event, or personal vulnerability, or both. Various anticipatory and participatory techniques are reviewed and initial guidelines are suggested for their selection in averting crises.

689. **Schwartz, S.L. (1971). A review of crisis intervention programs. *Psychiatric Quarterly, 45,* 498–508.**

A review of crisis intervention programs is presented. Review of the denotative usage of the term crisis in the psychiatric literature of the past 25 years indicates three distinct concepts: (1) developmental crises, (2) accidental crises, and (3) the acute onset of psychiatric disability or acute exacerbations in the course of chronic disability. However, common to all is a body of crisis theory embracing the characteristics of crisis itself, the progressive stages of individual response to crisis, and general principles of crisis intervention. Programs of crisis intervention are reviewed from the vantage of primary and secondary prevention. Intervention in the developmental and/or accidental crises of heretofore healthy individuals (primary prevention) is described. It is concluded that the goal of crisis intervention is never merely the resolution of the crisis. Crisis, by definition, is always terminable. Intervention seeks as its goal a higher order of resolution than would be provided by nature or chance alone. (Author abstract)

690. **Smith, L.L. (1977). Crisis intervention theory and practice: A review of the literature. *Community Mental Health Review, 2,* 1; 5–13.**

The current status of crisis intervention theory and practice is reviewed, and the literature on the following areas is critically evaluated: (1) childhood and adolescent crises, (2) mental health problems, (3) marital and family conflicts, (4) emergency hospitalization, and (5) suicide prevention. Despite the fact that crisis intervention has become a popular model of social intervention, many experts believe crisis intervention is not yet a well-defined treatment model. Suggestions and recommendations are made for improving crisis intervention theory and practice.

691. **Szyrynski, V. (1968). Crisis theory and preventive intervention. In F.C.R. Chalke, & J.J. Day (Eds.),** ***Primary prevention of psychiatric disorder*** **(pp. 162–168). Toronto: University of Toronto Press.**

It has been found that mental health assistance, provided promptly during times of individual crisis, makes possible better results with a relatively minimal expenditure of professional time and effort. Crises, both "accidental" and developmental, represent situations in which defense mechanisms are mobilized to deal with stress. This may result in a disorganization and regression of the personality or in a healthy reorganization of defenses that leaves one better able to cope with future crises. The role of primary prevention at these times is to intervene before the individual begins to decompensate, thus preventing further disintegration and helping to resolve the crisis satisfactorily. Crisis intervention consists of sympathetic, immediate contact with the person or group experiencing crisis. Its goal is to orient the individual or group to current reality. It allows the individual to go through appropriate emotional reactions of grief and mourning.

692. **Tyhurst, J.S. (1957). The role of transition states—including disasters—in mental illness. In Walter Reed Army Institute of Research,** ***Symposium on preventive and social psychiatry*** **(pp. 149–169). Washington, DC: U.S. Government Printing Office.**

This paper first describes research conducted by the author and colleagues on life circumstances involving significant change or transitions in individuals' life situations. Civilian disaster, migration, and industrial retirement constitute the research areas. Each of these three life situations is described in terms of the phases that characterize them. Conceptual approaches to crisis and theory are thus presented as an overarching perspective on transition states, and implications for preventive psychiatry are drawn. Included in these implications are the importance of preparing persons to anticipate the new situation, the importance of timing interventions to coincide with the period of turmoil when crisis is not able to be anticipated, and use of the social environment through the concepts of ritual and the concept of transitional community.

693. **Webb, N.B. (1981). Crisis consultation: Preventive implications.** ***Social Casework, 62,*** **465–471.**

The close relationship between crisis intervention and prevention is discussed in the context of social work consultation with preschool and senior citizen centers. The location of service in community settings provides opportunities to reach nonclient populations facing either anticipated or unanticipated crises. Prevention is often a serendipitous byproduct of effective social work practice, although it is not usually earmarked as a major practice goal, nor is it frequently identified as an important outcome of service. This model represents a blending of mental health consultation and crisis intervention techniques, with a flexible, time-limited application of direct service, to maximize the preventive potentials of social work practice. (Author abstract modified)

694. **Wiszinckas, E. (1982). Preparing children for situational crises.** *Journal of Children in Contemporary Society, 14,* 21–25.

The author suggests that a situational crisis is a "dangerous opportunity" to which a child may either succumb through symptom development or emerge with increased strength and mastery. Adults can help a child master such stress by preparing him/her for the forthcoming crisis. Guidelines for performing anticipatory guidance are offered. ©APA.

See also: 20, 69, 70, 95, 219, 267, 355, 713, 753, 767.

B. Crisis Intervention with Individuals and Families

695. **Capone, M.A., Westie, K.S., Chitwood, J.S., Feigenbaum, D., Good, R.S. (1979). Crisis intervention: A functional model for hospitalized cancer patients.** ***American Journal of Orthopsychiatry, 49,*** **598–607.**

A model for psychosocial rehabilitation of hospitalized oncology patients, found to be effective in use with gynecologic cancer patients, is described. Emotional strengths and defenses that will be most effective in enabling patients to mobilize their emotional resources must be identified. The intervention process is conceptualized in terms of four broad areas: (1) shaping experiences, (2) information processing, (3) adaptive behavioral change, and (4) integration. The model, which is based on a crisis intervention approach, is designed for the prevention and early identification of emotional distress.

696. **Dixon, K. (1982). Personal crisis and psychiatric emergency: Commentary on case mismanagement in crisis clinics. *Crisis Intervention*, 12, 24–35.**

This article distinguishes between the concepts of crisis and psychiatric emergency and discusses the implications for how interventions in crisis clinics are handled. Traditional psychiatric protocols are critiqued, and it is suggested that crisis workers should become more conscious of and committed to the value of prevention in mental health services. It is argued that prevention values are most likely to occur in crisis agencies that are dissociated from institutional psychiatry and more closely aligned with public health and indigenous community programs. The case of a 35-year-old white male illustrates a typical incidence of case management in a busy crisis intervention center. It is concluded that responsible crisis management will begin with the recognition of the distinction between emergency situations and crisis states, with a major commitment by the crisis worker to a proactive planning process with the healthy person in crisis. ©APA.

697. **Felner, R.D., Norton, P.L., Cowen, E.L., & Farber, S.S. (1981). A prevention program for children experiencing life crisis. *Professional Psychology*, 12, 446–452.**

The development and evaluation of a preventively oriented crisis intervention program for young children are described. Fifty-seven primary grade children who were experiencing the crisis-predisposing events of parental death, divorce, or remarriage; major elective surgery; or birth of a sibling were seen by trained nonprofessional child aides in the school setting. Child aides employed abreactive and problem-solving techniques during twice weekly meetings with children over a period of 6 weeks. Program children showed significant improvement on measures of school adjustment problems and competencies, as well as on a measure of trait anxiety. Analyses indicate that the program was most effective with children for whom the life events seemed most crisis precipitating. Problems with the delivery of preventively oriented crisis services for children are discussed, and the viability of such services is elaborated. (Author abstract) ©APA.

698. **Jaffe, P.G., Thompson, J.K., & Paquin, M.J. (1978). Immediate family crisis intervention as preventive mental health: The family consultant service. *Professional Psychology*, 9, 551–560.**

The authors describe a service that employs mental health personnel who work closely with the police in order to respond immediately to family-related crises. This paper reports on a preliminary evaluation of the program with respect to five issues: (a) whether the program is redundant with existing community services, (b) the advantages of early intervention approaches, (c) whether the program is a preventive service to any degree, (d) the evaluation of the program by the police and social agencies, and (e) whether cooperation between mental health and law enforcement professionals is enhanced. Available data collected over a 2-year period concerning these five issues indicated the success of the program. It is concluded that it can serve as a model for community prevention approaches to family crises and mental health problems. ©APA.

699. **Kliman, A.S. (1975). Primary crisis intervention. *Archives of the Foundation of Thanatology, 5,* 462.**

At a symposium on death, the press, and the public, held in New York City, February 1976, primary crisis intervention as practiced by the center for Preventive Psychiatry was discussed. Intervention is focused on children who are going through potentially damaging situations. The death of a parent or other family member accounts for many of the center's crisis cases. In these situations, the bereaved child (or adult) is helped to deal with the loss and to mourn in a healthy, constructive way. The center's approach to bereavement counseling is basically that of helping the patients to remember so that they can forget. (Author abstract modified)

700. **Louis, T., & Wortman, M. (1965). A program sponsored by a labor union, for treatment and prevention of psychiatric conditions. *American Journal of Orthopsychiatry, 33,* 584–592.**

The Labor Health Institute (LHI) is a program organized to provide comprehensive medical care to members of a Teamsters Union and their dependents. Presenting their broad concept of health maintenance, the authors argue that one's state of health is a function of a large number of factors--physical as well as cultural, familial, and personal. The authors advance their proposal for an integrated program aimed at reducing incidence of mental illness, prevalence of psychiatric disorders, and the severity of residual disabilities. A crisis intervention program is designed to help individuals adapt to such stressful situations as bereavement, divorce, illness, and so on. This preventive intervention program would enable monitoring, through the union business office and the shop stewards, of individual responses to crisis situations and work-related problems. In addition to finding cases, union stewards, foremen, and others could be utilized to deal with consultants. The family and the work place, as sources of stress, could also be dealt with in such a manner that disturbed functioning of these systems might be altered.

701. **Parad, H.J. (1965). Preventive casework: Problems and implications. In H.J. Parad (Ed.), *Crisis intervention: Selected readings* (pp. 284–298). New York: Family Service Association of America.**

The author proposes that a carefully focused "retail" program of casework intervention with families under stress should be systematically and comprehensively included in the total spectrum of services to implement and bolster the effectiveness of "wholesale" methods of preventing family breakdowns. More rational organization of family-oriented services will enable us to serve a larger number of families with an increasingly effective type of preventive intervention. The focus of these interventions is on acute situational reactions characterized by temporary but intense emotional disequilibrium states that, if unrelieved, would predictably lead to serious personality disorder, affecting not only the immediate individual but also a larger circle of significant others. The intervention techniques employed are intended to satisfy the individual's needs for support and relief of tension. These techniques include specific emotional support, clarification, and anticipatory guidance. Thus, this efficient use of professionals' time and resources in clinical casework serves to prevent more serious mental health problems.

702. **Rapoport. L. (1962). Working with families in crisis: An exploration in preventive intervention. *Social Work, 7*, 48–56.**

This paper describes preventive intervention work done with families considered to be at risk and in crisis because of the birth of a premature infant. Characteristics of the state of crises are first defined, including the fact that it is time limited, progresses through predictable phases, and is a time when persons are particularly susceptible to influence. The intervention study itself is then described and includes home interviews with 11 families with premature infants. The interviews are brief and are begun during the first week after the mother returns from the hospital. Three illustrative cases are presented, and three broad categories of interventions emerge: (1) keeping an explicit focus on the crisis, (2) offering basic information and education, and (3) creating a bridge to community resources.

703. **Safran, C. (1973). How mental first aid can pull you through a crisis. *Today's Mental Health, 51*, 42–45.**

Several case histories illustrate that getting psychological help in times of severe stress serves to head off more serious mental problems. During crises people typically bury emotions they don't understand and don't know how to deal with. Crisis intervention helps people deal with problems when they arise. There is a correlation between personal tragedy and physical illness. One study discovered that 60 percent of the patients on the surgery ward for nonelective surgery, at a randomly chosen period, were people who had suffered a major loss within 6 months prior to surgery. It is felt that suicide hot lines and rape clinics, as well as hospital programs that offer psychological guidance and emotional support to seriously ill or dying patients and their families, are the beginnings of preventive psychiatry. (Author abstract modified)

704. Waldfogel, S., & Gardner, G.E. (1961). Intervention in crises as a method of primary prevention. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 307–322). New York: Basic Books.

A crisis intervention approach is applied to the problem of school phobia. It is postulated that crises vary along a continuum that represents the relative influence of internal and external causes. Internal causes are presumed to stem primarily from intrapsychic factors related to unresolved crises in the past. Included among external factors are such events as parental death or early separation. A case study is used to exemplify the possible interaction of external and internal sources of crisis. Based on these premises, an early detection and intervention program for emotional problems in the early school years is briefly outlined.

See also: 19, 64, 92, 569, 597, 605, 624, 692, 748, 769, 773, 789, 860, 896, 931, 950, 993, 1001, 1004.

C. Crisis Intervention Following Disasters

705. Arieli, A., & Reznik, R. (1979). A community psychiatry service in Maalot. *Israel Annals of Psychiatry & Related Disciplines, 17*, 278–290.

The authors describe the development of a community psychiatric service over a 5-year period. The service was started by crisis intervention following a terrorist attack in Maalot. Treatment was by conventional psychiatric therapy combined with primary and secondary preventive techniques. One hundred persons (aged 18 years and over) visited the clinic. Statistical data obtained by a questionnaire indicate that the service was well received by Ss needing welfare services. However, the treatment of marital and socioeconomic problems was less successful. ©APA.

706. **Kliman, A.S. (1977). Psychological counseling and facilitation of mourning following a large disaster.** ***Archives of the Foundation of Thanatology, 6,*** **99.**

A summary of a paper on psychological counseling and facilitation of mourning following a large disaster is presented. It is believed that a mass tragedy stimulates community cohesiveness and offers the opportunity during the initial phase of mourning to facilitate healthy adjustment to loss and to prevent pathological outcome for the individual, the family, the extended family, and the community. Materials that provide a demonstration of psychological first aid following a flood and a tornado are discussed. It is suggested that immediate intervention is necessary because communities tend to polarize and families to fracture after the initial phase of cooperation, empathy, and altruism. (Author abstract modified)

707. **Klingman, A., & BenEli, Z. (1981). A school community in disaster: Primary and secondary prevention in situational crisis.** ***Professional Psychology, 12,*** **523-533.**

The primary and secondary preventive actions of a local school psychological service (SPS) in Israel following an extreme emergency are described. Following a terrorist attack on an Israeli neighborhood in April 1979, the local SPS reorganized its staff to make its services available to neighborhood schools, using the primary prevention and the secondary prevention models. Primary prevention included advising school staff as to children's reactions to the stressful situation and how to handle them, enhancing opportunities for positive experiences, and giving support to school staff. (Author abstract modified)

708. **Raphael, B. (1980). A primary prevention action programme: Psychiatric involvement following a major rail disaster.** ***Omega, 10,*** **211-226.**

A primary prevention program implemented immediately following a major rail disaster in Granville, Australia, is described. Because of the high mortality, services were oriented toward the provision of preventive counseling for bereaved families as well as support for the injured. Emergency counseling services were provided at the city morgue. Subsequently, coordinating, consultative, and educational programs were instituted in the affected health region. Counseling bereaved families was continued through appropriate specialized community services. High-risk groups of bereaved were delineated and special emphasis was given to individual care of these persons. Recommendations are made concerning the relevance of such a program to the personal disasters of life.

709. **Richard, W.C. (1974). Crisis intervention services following natural disaster: The Pennsylvania recovery project. *Journal of Community Psychology, 2,* 211–219.**

Project Outreach, a program conducted in eastern and central Pennsylvania to provide preventive, interventive, and restorative human services to flood victims of hurricane Agnes is described. Established with the aid of an NIMH grant, the 1-year project was based on a crisis intervention model using 63 trained paraprofessional human service counselors working in homes and neighborhoods. The paraprofessionals were trained in two phases: an intensive general orientation workshop for 1 week, followed by a series of inservice training meetings after trainees were functioning in their assigned roles. During the first 8 months of the project, over 1,500 cases were seen involving individuals, families, and neighborhood groups with a wide range of problems, including consumer/contractor complaints, alcohol abuse, emotional disturbance, family disturbances, financial crises, critical medical needs, unemployment, mobile home maintenance, and substandard temporary living conditions. The project is considered an example of a disaster relief program that emphasizes the psychological and psychosocial aftereffect of a natural disaster.

710. **Tierney, J.J., & Baisden, B. (1979). *Crisis intervention programs for disaster victims in smaller communities.* (DHEW Pub. No. (ADM) 79–675). Washington, DC: U.S. Government Printing Office.**

This 200-page publication was written to provide theoretical and practical knowledge that can aid personnel at the State and locals level in planning and carrying out disaster-related mental health programs. The report makes recommendations for post-disaster mental health programs based on research findings in the area. The report also attempts to provide the mental health professional or layperson interested in mental health problems of rural populations with information that can remedy these problems. To this end, issues of disaster mental health, characteristics of individual and group behavior in disasters, and emergency mental health program development are discussed. This monograph also reports the findings of a research project conducted by personnel of The Disaster Research Center at Ohio State University who assessed the need for crisis intervention services in nonurban United States communities as well as the availability of local resources capable of providing such services. The authors also provide guidelines for the planning and operation of disaster-related emergency mental health programs. Finally, a selected annotated bibliography is provided that lists articles of three different types: (1) general social-scientific writings on disaster and disaster planning, (2) recent literature on rural mental health needs and programs and selected works on community mental health and crisis intervention, and (3) mental health consequences of disaster and the delivery of services to victims.

See also: 692, 744, 889.

XII. Primary Prevention Following a Specific Stressful Life Event

Articles in this section describe preventive interventions with individuals who are undergoing a specified and similar stressful life event. In contrast to many of the preventive interventions described in the previous section on crisis intervention, articles in this category define the specific type of stressful event that might produce psychological disorders in those experiencing it.

Articles have been subdivided into three primary categories: (1) those providing reviews and conceptual discussions related to stress, coping with stress, and preventive interventions following stressful life events; (2) those describing interventions with children undergoing a stressful life event; and (3) those describing interventions with adults undergoing a stressful life event. Within the latter two categories, there is further subdivision based on the exact nature of the stressful event. This subdivision categorizes articles dealing with children or with adults experiencing (1) the recent death of a family member, (2) separation/divorce, or (3) another miscellaneous but specific stressful event.

A. Reviews and Conceptual Discussions

711. **Allen, L., & Britt, D.W. (1983). Social class, mental health, and mental illness: The impact of resource and feedback. In R. D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 149–161). New York: Pergamon.**

In this chapter, the correlation between social class and prevalence of symptoms of psychological disorder is examined; competing arguments for explaining the direction or existence of causation are considered; and the authors introduce the roles of feedback, resources, and life stress into the model. The resources available to a particular individual in times of stress are classified as either social (i.e., support networks), economic, or personal (i.e., coping strategies). It is suggested that these resources may have independent effects on both stressful life events and psychological disorder and that the effects may differ across different social classes. Furthermore, the authors propose that it is the vulnerability of each class of resources that is most critical in predicting their effects on psychological functioning. The implications of this model for preventive interventions are discussed.

712. **Arsenian, J. (1965). Toward prevention of mental illness in the United States. *Community Mental Health Journal, 1*, 320-325.**

The article begins with the proposition that every human has a threshold for disorganization of behavior or personality, based on the degree of tension experienced by the person. Three situational determinants of stress and tension are identified: loss, ideological stress (confusion), and conflict. These conditions are linked to both the biological and social life cycles of individuals in society. The critical hypothesis of the article is: "If 'transitional supports' were introduced--or strengthened--where existing arrangements do not enable some people to sustain tension more comfortably or to discharge it, then we could reduce the incidence of 'breakdowns.'" The roles of loss, confusion, and conflict in heightening levels of tension are briefly outlined and discussed. A table of potential sources of tension-overloading and some theoretical remedial actions are presented, as are some illustrative applications.

713. **Bloom, B.L. (1971). Strategies for the prevention of mental disorders. In G. Rosenblum (Ed.), *Issues in community psychology and preventive mental health* (pp. 1-20). New York: Behavioral Publications.**

Two main categories of strategies are available for the primary prevention of mental disorders: One is to increase individual resistance to stress-inducing psychosocial forces within the community; the other is to reduce these stresses. The first strategy requires identification of persons in crisis and brief intervention to help them resolve the crisis in a favorable manner, the second one requires intervention in the community. The problem of identification of the individual in need of help can be attacked by: (a) aiming programs at the total population in a defined geographical area, (b) implementing preventive milestone programs (at predefined points in an individual's life), and (c) identifying groups of persons with a high risk of developing particular sets of behaviors. Unfortunately, at present, the essential characteristics of the conditions to be prevented are not well defined. The research base of primary prevention will have to be rooted in the science and methods of epidemiology. The social scientists need to familiarize themselves with the field and its methods of approach so that they can apply them to the identification of causal factors in mental disorders, however defined.

714. Cassel, J. (1974). Psychosocial processes and "stress": Theoretical formulation. *International Journal of Health Services, 4*, 471–482.

In searching for the factors that lead to disease, epidemiological investigators have expanded the concept of the environment from the physical and microbiological to include the social. Attempts to understand how this social influence operates have, however, been inconclusive. The author suggests that this is due in large part to an inadequate theoretical conceptualization of the issue, much of the difficulty lying in a misinterpretation of stress theory. Rather than directly "causing" disease, the author argues that psychosocial processes act as "conditional" stressors, altering the endocrine balance of the body and hence increasing susceptibility to disease agents that act directly. The disease manifestations are thus a function of the direct noxious stimuli and of constitutional factors. Presenting data from both human and animal studies, the author asserts that these psychosocial processes consist primarily of disruptions of normal social relationships, to which members of a given population are differentially susceptible. Among protective factors are certain biological and social adaptive processes, especially the presence of group support for the individual. Rather than reducing exposure to social stressors, it may be better to improve and strengthen social supports. To facilitate this, professionals could be used in a largely diagnostic role, while intervention could be undertaken by nonprofessionals given adequate guidance and specific direction.

715. **Danish, S.J., Smyer, M.A., & Nowak, C.A. (1980). Developmental intervention: Enhancing life-event processes. *Life-span Development and Behavior, 3*, 339–366.**

Current trends in critical life events and intervention are considered, and it is argued that the events framework provides a conceptual focus for developing preventive strategies and enhancing interventions. Characteristics and types of critical individual and cultural life events are delineated, including the empty nest syndrome, menopause, retirement, and institutionalization. Interventions are distinguished based on the timing of the action in relation to the life event. It is concluded that age related life events that have a high likelihood of occurring are most amenable to prevention and enhancement. Because such events are predictable and expected, interventions can be implemented prior to their occurrence. Two conceptual frameworks that have influenced interventions are discussed: disease and developmental approaches. An attempt is also made to contrast prevention and enhancement by considering the theory of human behavior that is inherent in each. It is concluded that by linking critical and stressful life events to intervention strategies, the most effective and efficient helping programs can be developed. (Author abstract modified)

716. **Dooley, D., & Catalano, R. (1977). Money and mental disorder: Toward behavioral cost accounting for primary prevention. *American Journal of Community Psychology, 5*, 217–227.**

The article reviews recent retrospective sociological research suggesting that rises as well as falls in the economy are associated with such indicators of mental disorder as suicide and mental hospitalization. The review emphasizes that a lag exists between economic change and the changes in associated mental indicators. It is suggested that these findings hold promise both for early warning for practitioners and for primary prevention. Also described is a survey in four centers of 93 community mental health workers, indicating that such workers are receptive to the use of such economic indicators but not well informed about them. Suggestions are made for prospective research relating economic change to mental disorder through such intervening constructs as life change and stress. Such research, it is hoped, would expand the capacities of community psychologists to account for the behavioral costs of economic policy alternatives. ©APA.

717. **Dubreuil, G., & Wittkower, E.D. (1977). Primary prevention: A combined psychiatric–anthropological appraisal. In J. Westermeyer (Ed.), *Anthropology and mental health: Setting a new course* (pp. 125–144). Chicago: Aldine.**

The authors address the question, "Do psychiatrists and anthropologists have coherent and clearly defined guidelines (theoretical, social, cultural, or ideological) by which they can engage in an enlightened policy of prevention of mental illness?" They address issues of past developments in both fields, the bases of knowledge of the relation between mental health and sociocultural factors, and who should do what with regard to prevention. They purport that the specific sociocultural stresses predispose members of that culture to certain pathologies, but they also stress that culture itself provides spontaneous mechanisms of primary prevention. These include a world view that gives meaning to human life and behavior, mechanisms that serve as emotional outlets, and techniques for treating those seen as "abnormal," "marginal," or "criminal." Scientists must be aware of their own cultural and ideological biases in understanding practices of other cultures. They conclude that there is little on a large scale that psychiatrists and anthropologists can do in the name of primary prevention, although there is much they can do in the field of secondary prevention.

718. **Felner, R.D., Farber, S.S., & Primavera, J. (1983). Transitions and stressful life events: A model for primary prevention. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 199–219). New York: Pergamon Press.**

Theory and research on the relationship between stressful life events and psychological adaptation are presented in two sections: the occurrence of multiple life events (reviewing the work of Holmes and Rahe and others), and the impact of single life events (including a model developed by Dohrenwend). The authors then make a distinction between life stress and life transitions, both of which are embedded in the stress research literature. They highlight the necessity of understanding the adaptive challenges confronted by individuals experiencing life change and the need to develop a health orientation in development of preventive interventions. It is proposed that life transitions--such as marriage, divorce, birth of children, starting school, etc.--are qualitatively different from stressful, circumscribed events. A life transition approach is believed more useful than a stress approach in determining the elements of the structure of transitions that may be salient for adaptation and for formulating preventive programs.

719. **Konopka, G. (1980). Stresses and strains in adolescents and young adults. In L.A. Bond & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competence and coping during adulthood* (pp. 178–194). Hanover, NH: University Press of New England.**

The concept of adolescence is first addressed, and the author explores some of the key experiences that are unique to this developmental period. Some of these experiences include the development of sexual maturity, the withdrawal of and from the benevolent protection of adults, a greater sense of consciousness of self in interpersonal interaction, a reevaluation of values, a more active participation in the affairs of society, and a tremendous sense of physical energy. The most significant institutions in an adolescent life today--the family, the school, the place of work, and the peer group--are each briefly discussed in terms of their effects on youths. The concept of coping and the process of coping with stresses and strains during adolescence is then explored. Four means of coping are mentioned: (1) communication with peers, (2) communication with adults, (3) organized religion, and (4) creative expression of emotions, as in songs, poetry, and painting. Finally, suggestions for how mental health professionals and other adults can help adolescents in coping with the realities of life are given. The foremost suggestion is to help adolescents develop a philosophy of life.

720. **Lazarus, R.S. (1980). The stress and coping paradigm. In L.A. Bond, & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competence and coping during adulthood* (pp. 28–74). Hanover, NH: University Press of New England.**

The author discusses his and others' research and theories regarding stress and coping. The major tenets of stress and coping theory are examined, including an interest in naturalistic versus laboratory studies, studying "transactions" between persons and environments, the use of multiple levels of analysis (e.g., biological, psychological, social systems) and ipsative-normative ways of studying individuals. The author discusses substantive cognitive and coping concepts such as "primary appraisal," "reappraisal," and "secondary appraisal." The author next explores in detail the concept of coping. Four main modes of coping are identified and discussed: (1) information-seeking, (2) direct action, (3) inhibition of action, and (4) intrapsychic processes. Problems in doing research on the coping process of individuals are listed. The author states that little is now known about the patterns of coping employed by different people, the patterns of coping that work for given types of individuals, the way they work, and the specific sets of circumstances under which they work. Finally, the author discusses seven implications of his ideas on stress and coping for the study of human functioning.

721. **Levinson, H. (1980). An overview of stress and satisfaction: The contract with self. In L.A. Bond & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competence and coping during adulthood* (pp. 224–239). Hanover, NH: University Press of New England.**

Satisfaction and dissatisfaction with work is the primary topic in this article. Three circumstances in the work environment that can precipitate stress are discussed. Such circumstances include when feelings of helplessness or inadequacy increase, when people's values and personal rules of behavior are violated, and when people feel they are not moving towards their ideal perception of where they ought to be in their career. The author discusses some of the sources of dissatisfaction with work from a psychoanalytic perspective. Finally, the author mentions problems and processes of coping with the stresses and strains of the work environment. The benefits of mutual-support groups as a means of helping people cope with work-related problems is suggested.

722. **Milsum, J. H. (1980). Health, risk factor reduction and life-style change. *Family and Community Health*, *3*, 1–13.**

Within the context of prevention and health promotion, risk factors and lifestyle change are discussed. Four aspects of health are delineated: the physical; the mental, intellectual, cognitive, and emotional, which are increasingly recognized as playing a major role in health and illness; the social/cultural; and the spiritual. While passive prevention strategies (such as clean water and vitamin supplementation of milk) play a valuable role, full health must result primarily from self-motivated active strategies. A multifactorial risk factor model of health/illness dynamics is presented that considers physical and psychological stressors, exercise, nutrition, stress control (relaxation), and hereditary predispositions. The outcome of these multiple factors is the stress level within the individual. The typical responses to stress include alarm, resistance, and general exhaustion; these are similar to the fight/flight response. Once aware of stress and risk factors, actions can be taken to reduce stress and risk through behavioral stress management and lifestyle change of those discretionary behaviors associated with risk. Public education and counseling approaches to facilitating stress reduction/lifestyle modifications are discussed.

723. **Rutter, M. (1979). Protective factors in children's responses to stress and disadvantage. In M.W. Kent, & J.E. Rolf (Eds.), *Primary prevention of psychopathology, Vol. 3: Social competence in children* (pp. 49–74). Hanover, NH: University Press of New England.**

The author explores factors and circumstances that provide support, protection, or amelioration for children reared in deprivation and therefore considered at high risk for negative outcomes. The frequencies of good and poor adjustment related to multiple environmental risk and protective factors are examined. The author argues that his epidemiological data yield important clues to methods of increasing the self-protective capacities of children at high risk. Protective factors include compensating experiences outside the home, the development of self-esteem, the scope and range of available opportunities, the availability of personal bonds, and the acquisition of coping skills.

724. **Smith, W.G. (1971). Critical life-events and prevention strategies in mental health. *Archives of General Psychiatry*, *25*, 103–109.**

The relationship between onset of serious mental disorder and the occurrence of 37 crisis or stress events was studied as a potential focus for a preventive community program. Seven life events occurring within 1 year prior to treatment were associated with serious mental disorder: being hospitalized for mental disorder, suicidal attempt, trouble with the police, onset of heavy drinking, loss of job, divorce or separation, and a family member beginning heavy drinking. None of these risk markers were associated with alcoholism. Only two markers, divorce or separation and onset of drinking in a family member, tended to precede the onset of mental disorder. These markers may be useful as foci for a primary prevention program. A population-wide approach to prevention of major mental disorder awaits a clear identification of factors that can be controlled. (Author abstract)

See also: 16, 27, 35, 37, 38, 49, 50, 90, 106, 108, 113, 123, 148, 158, 188, 422, 623, 632, 636, 645, 655, 669, 680, 692, 771, 798, 799, 801, 802, 885, 892, 951, 953.

B. Intervention with Children

1. Primary Prevention Following Death of Family Member

725. **Adams-Greenly, M., & Moynihan, R.T. (1983). Helping the children of fatally ill parents.** ***American Journal of Orthopsychiatry*, *53*, 219–229.**

The article outlines a sequence of preventive interventions for children during the course of a parent's fatal illness based on a literature review of children's mourning and their perceptions of death. Infants feel abandonment at a parent's death; a preschooler may be concerned with the physical features of the dead, separation, and the idea of death as punishment. As children progress through the Piagetian stages, they can perceive the biological and abstract qualities of death. Adolescents may overidealize the dead parent and direct more hostility toward the surviving parent. A surviving parent can aid in the application of psychosocial interventions for children of a dying or dead parent by (1) realizing that their own loss and that of the children are different, (2) being supportive of the child's painful feelings, (3) maintaining a familiar routine, and (4) using psychotherapeutic tools to validate the child's experience. Other psychosocial interventions may include providing age-appropriate information, arranging hospital visits, interpreting the medical status, preparing for the death, and providing followup contact. ©APA.

726. **Aradine, C.R. (1976). Books for children about death.** ***Pediatrics*, *57*, 372–378.**

Books about death for preschool and school-aged children are reviewed in terms of child development, children's understanding of death, and literary quality. The goal is to help pediatricians and nurses become aware of this literature and to aid them in selectively advising concerned parents about its constructive use to help children understand death. Preventive mental health is the focus rather than use with fatally ill children. (Author abstract modified)

727. **Cain, A.C. (1972). *Survivors of suicide*. Springfield, IL: Charles C. Thomas.**

Papers discussing effects of suicide upon young children, spouses, and parents of adolescent suicides are presented. Psychoanalytic case studies, family interaction case analyses, clinical investigations, psychotherapy, individual and family approaches, and many other important topics are included. Future directions and key problems for research and preventive services are suggested.

728. **Feinberg, D. (1970). Preventive therapy with siblings of a dying child. *Journal of the American Academy of Child Psychiatry, 9*, 644–668.**

The author discusses factors in the psychoanalytically oriented treatment of two girls aged 7 and 9, whose 6-year-old brother was dying of leukemia. Each sister was seen separately and weekly for a period beginning 8 months before the brother's death until 2 months afterwards. The therapist discusses the therapy in terms of five types of interaction: (1) persistent attempt to deal with the threatened loss in a forthright manner, (2) the stimulation and encouragement of "immunizing" discussions, (3) encouragement of catharsis without extremes of regression, (4) emphasis on attention to the details of reality, and (5) direct initiation and enhancement of mourning using transference material whenever possible. The author suggests that true "adult mourning" requires passage through normal adolescence and is distinct from "childhood mourning," which is a healthy childhood response to object loss.

729. **Felner, R.D., Ginter, M.A., Boike, M.F., & Cowen, E.L. (1981). Parental death or divorce in childhood: Problems, interventions, and outcomes in a school based mental health project. *Journal of Prevention, 1* 240–246.**

Children with histories of parental separation/divorce or death in a school-based helping program with nonprofessional child-aides were compared directly to each other and to referred children without such histories on initial referral problems, treatment goals, and outcome measures. Children with separation/divorce histories were rated by child-aides as having more serious acting-out problems at referral. Aides also set more treatment goals aimed at reducing acting-out for such children than for those with parental death or without such histories. Child-aides also tended to rate children with histories of parental death as having more serious shy-anxious problems and set more treatment goals aimed at reducing such problems than for separation/divorce children. No consistent outcome differences were found between the groups. Implications of these findings for future program direction are discussed. The need for more truly preventive programming for children experiencing such events is emphasized. (Author abstract) ©Human Sciences Press.

730. **Gardner, R.A. (1979). Death of a parent. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 270-283). New York: Basic Books.**

This article addresses issues in helping children deal with the impending or actual death of a parent. The process of mourning is discussed from a psychoanalytic perspective with an emphasis on ways to help facilitiate healthy mourning at the time of parental death. Important components of this process include helping the child to cope with grief, with anger, with worries concerning their own and their living parent's mortality, with forming a substitute relationship, and with forming a healthy identification with the dead parent. Early pathological reactions to parental death that stem from failure of the child to experience successful mourning are then discussed. Such reactions can take the form of denial, suppression, repression, guilt, regression, depression, and pathological identification. The author views the death of a parent as a crisis in the life of a child and one that holds the potential for the later development of pathology if not dealt with effectively. However, it also holds the potential for a successful resolution and beneficial channeling of energies.

731. **Koch, J. (1977). When children meet death. *Psychology Today, 11*, 64-66, 79-80.**

The activities of the Barr/Harris Prevention Center for the Study of Separation and Loss During Childhood, a psychiatric center established to help children adjust to the loss of a parent, are described. Therapy is directed at helping both the child and the surviving parent to express their grief in order to prevent an arrest of emotional growth. In addition, the center carries on research and community education activites. The role of the loss of a parent in the lives of several well-known people is explored.

732. **Nelson, R.C., Peterson, W.D., & Sartore, R.L. (1975). Issues and dialogue: Helping children to cope with death.** ***Elementary school guidance and counseling, 9*****, 226–232.**

Ways of helping children cope with death are discussed, and issues related to the way society deals with the topic and the reality of death are presented. Initiating frank, honest classroom conversation about death is suggested as a form of preventive counseling. Issues discussed include the extent to which one should be honest with children about the death of someone close to them; whether children should attend funerals and other rituals; and whether the counselor should view children as the only people to be concerned about when the topic of death is to be considered. Resources and activities relevant to children and death are suggested for counselors. It is concluded that proactive rather than reactive guidance programs are needed, since such programs prepare children for coping with death prior to the time they have to face it.

733. **Ryerson, M.S. (1977). Death education and counseling for children.** ***Elementary school guidance and counseling, 2*****, 165–174.**

Elementary level counseling as an avenue for preventing destructive behavior patterns in children after the death of a loved one is presented. Methods are suggested, such as positive responses to questions, encouragement of expression of feelings, lessons on animal life cycles, discussion of children's stories dealing with death, role-playing, and art activities. Examples are given of how these approaches help the child work out feelings of guilt, suppressed anger at being abandoned, and general anxieties that can lead to antisocial behavior patterns. It is concluded that effective counseling can help a child accept death as an inevitable part of life.

734. **Valente, S.M. (1980). Stressors at school age.** ***Family and Community Health, 2*****, 15–29.**

Stressors affecting the school-age child, the child's understanding and response to stressors, and the child's coping mechanisms are discussed. The need for support when children must cope with bereavement, adoption, and illness is discussed. Approaches to helping the child manage stress are suggested, including: effective communication, anticipatory planning, psychotherapy, art, play, expanding social resources, peer education and counseling, and understanding the child's growth and development. A health monitoring program, including a complete physical/mental/behavioral/

social examination, observation tests and followup, as well as an annual dental examination, is recommended.

See also: 680, 697, 699, 997.

2. Primary Prevention Following Separation/Divorce of Parents

735. Anthony, E.J. (1974). Children at risk from divorce: A review. In E. J. Anthony, & C. Koupernick (Eds.), *The child in his family: Children at psychiatric risk: III* (pp. 461–478). New York: Wiley

Children of divorce are viewed as a group at risk for the development of psychiatric disturbance. Divorce is understood as an almost indefinite process of stages rather than a relatively short-term trauma, with each stage having its own psychological impact. Difficulties experienced by children at different stages in divorce are described, and the general need for extra support in order to prevent disturbance is emphasized.

736. Felner, R.D., Farber, S.S., & Primavera, J. (1980). Children of divorce, stressful life events, and transitions: A framework for preventive efforts. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy, and practice* (pp. 81–108). Beverly Hills: Sage.

The impact of parental separation and divorce on children is considered in light of literature on stressful life events. A review of literature in this area reveals two lines of research: the impact of the stressful event on children and the mediating factors that influence the adjustment of children to this event. The effect of parental divorce most consistently found is increased "acting out," antisocial and aggressive behavior. Documentation of intervention with this population is scarce, and most intervention efforts are not primarily preventive in nature. It is suggested that the literature on mediating and coping with stressful life events provides a framework for prevention with this group of children.

737. Gardner, R.A. (1979). Divorce. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 263–270). New York: Basic Books.

The author states that the child of divorce is more at risk to develop psychological disturbances than the child growing up in an intact, relatively stable home. Issues in therapists' interaction with parents prior to divorce, around the time of separation, in the early postseparation period, and at later times in the process are discussed. Issues are focused specifically on how parents can best act and react to the difficulties that separation or divorce may cause in their children.

738. **Gullotta, T.P. (1981). Children of divorce: Easing the transition from a nuclear family.** ***Journal of Early Adolescence, 1,*** **357-364.**

The author examines the literature on the effects of divorce on children. Findings indicate that divorce is stressful for both parents and their children. Parents seem to at least temporarily diminish in their capabilities to parent, and they experience feelings of loneliness, emptiness, and inadequacy. Their children experience disciplinary inconsistency and poorer sense of self in relationship to others. Relationships, particularly between mother and son, may be strained. Children are at greater risk for becoming involved in antisocial activities. The adult life of children whose parents were divorced does not seem to be particularly strained. However, marital satisfaction is reported to be lower and divorce rates higher for adults whose parents divorced when they were young. Four basic tools (education, competency promotion, community organization, and natural caregiving) are cited as useful to mental health workers in either consultation or collaboration with groups to reduce the chances that the stress of divorce for children will cause dysfunction. ©APA.

739. **Robson, B. (1982). Therapy with remarriage families: V. A developmental approach to the treatment of children of divorcing parents.** ***Family Therapy Collections, 2,*** **59-78.**

The author suggests that, as the divorce rate increases and elementary schools report increasing percentages of students living in single-parent homes or in reconstituted families, the development of preventive programming for children is essential. Because children's reactions to separation and divorce appear to be specific to their developmental phase, it is important that teachers, counselors, lawyers, and mental health professionals who come into contact with them during the process of separation be attuned to these developmentally related symptoms. Primary prevention for avoiding the development of later maladjustment and psychopathology can be accomplished through parental education and by providing educational programs within the school system. When symptoms are present, treatment should be focused on the particular individual's needs and be oriented toward the developmental stage of the child or adolescent. ©APA.

740. **Schulhofer, E. (1973). Short term preparations of children for separation, divorce, and remarriage of parents.** ***American Journal of Orthopsychiatry, 43,*** **248–249.**

This paper describes short-term preparations of children for separation, divorce, and remarriage of parents. Several methods of possible preventive help are offered. Children may be involved in a counseling session dealing with the crisis situation, clarifying and explaining on the children's level the facts that led to the situation. Regardless of whether the family is still intact, a family interview with all adults and children involved can give the children the feeling that there is and will be parental agreement on care of the children's physical and emotional needs and that the male-female identification models will not vanish. Children's reactions, in the form of anxieties and defenses, can be dealt with immediately by the parents and helpers.

741. **Wallerstein, J.S. (1983). Children of divorce: The psychological tasks of the child.** ***American Journal of Orthopsychiatry, 53,*** **230–243.**

Long-range outcomes for the child of divorce are related to factors within the family following divorce and to the child's mastery of specific threats to development, which are conceptualized in this article as six interrelated, hierarchical coping tasks. Beginning at the separation and culminating in young adulthood, these tasks add substantially to the normal challenges of growing up. (Author abstract modified) ©American Orthopsychiatric Association.

742. **Young, D.M. (1980). A court-mandated workshop for adolescent children of divorcing parents: A program evaluation,** ***Adolescence, 15,*** **763–774.**

This article provides a description and an empirical evaluation of a predivorce workshop established by the Family Court of Allen County, Indiana, for adolescent children (n=48) of divorcing parents. Highlighted are the concerns of the adolescents, the approaches taken by the workshop staff, and the impact of the program on the participants. Viewpoints on the clinical, ethical, and legal issues involved in "required" predivorce counseling for adolescents are presented. The preventive nature of the program, its means of transforming initial resentment toward the workshop experience into positive feelings, and the implications for future practice and research are also discussed. (Author abstract)

See also: 182, 183, 222, 680, 697, 819.

3. Primary Prevention Following Other Stressful Life Events

743. Barker, M. & Smith, K. (1981). A primary prevention program for migrant children in a Queensland high school. *International Social Work, 24*, 7–16.

This article describes an intervention program with newly arrived migrant and refugee students--predominantly Indochinese--in a Queensland, Australia, high school. Underlying the creation of the intervention was an effort to understand how the cultural backgrounds of the migrants and refugees related to the constraints and demands of the specific high school. The program, conducted by social workers who served as "facilitators," had as its broad goal the creating of a positive entry experience for the students, which included both an appreciation of their cultures and heritage and what alternative courses of action they could take in adapting to the high school. The specifics of the program are described in some detail, and analysis of the group dynamics is provided. Positive outcomes are discussed, and the usefulness of preventive interventions in general is underscored.

744. Benyamini, K. (1976). School psychological emergency interventions: Proposal for guidelines based on recent Israeli experience. *Mental Health and Society, 3*, 22–32.

The author presents guidelines for emergency interventions in schools, based on the mental health and counseling services that were available during the Yom Kippur War. The guidelines rest on the assumption that the planning and delivery of professional emergency interventions resemble those governing routine mental health services in several respects. Three categories of reactions to emergencies can be expected in schools: shock and grief, fear, and confusion. It is noted that stressful events can also generate positive effects. A preliminary assessment of the psychological problems in need of treatment is crucial. In the planning phase, decisions must be made about recipients of assistance, methods of help, and expanded levels of service. ©APA.

745. Bogat, G.A., Jones, J.W., & Jason, L.A. (1980). School transitions: Preventive intervention following an elementary school closing. *Journal of Community Psychology, 8*, 343–352.

A peer-led preventive orientation program, which was aimed at allaying detrimental effects of a forced school closing, was investigated. Students transferring into a public elementary school were matched by grade and sex with students currently enrolled at the public school. The groups of transfer students were then randomly assigned to either the orientation program or no program.

The 2-day, peer-led orientation program occurred 1 week prior to the beginning of school. Following the intervention, the group experiencing the orientation program was superior to both the students currently in the school and transfer students not given the orientation programs in terms of self-esteem related to peer relationships, knowledge of school rules, and teacher conduct ratings. The project indicates how community psychologists can respond to a crisis in the community by developing preventive interventions.

746. **Cromer, W.J., & Burns, B.J. (1982). A health center response to community crisis: Some principles of prevention and intervention. *Journal of Primary Prevention, 3,* 35–46.**

September 1975 saw implementation of Phase Two of mandatory busing of children in the Boston Public Schools. This article describes the experiences of the neighborhood health center in Charlestown, Massachusetts, prior to, during, and after the initial crisis period. Principles relating to prevention and intervention emerged that can be applied by community clinicians when they face potential or actual community crises. The article emphasizes health center efforts to intervene in the anticipatory stress that occurred prior to the onset of busing. The short- and long-term effects of the crisis on the neighborhood and on the health center are briefly discussed. (Author abstract) ©Human Sciences Press.

747. **Holland, J.V., Kaplan, D.M., & David, S.D. (1974). Interschool transfers: A mental health challenge. *Journal of School Health, 44,* 74–79.**

Interschool transfer (IST) children who have to adapt to a new school because their families have left one community to settle in another are seen as constituting a high-risk group whose long-term adjustment to school may be jeopardized by the transfer experience or who may require special assistance to master this transition successfully. Reasons for viewing the IST child as a higher-risk child are given, and the magnitude of the problem is suggested. The coping process experienced by the IST child is described, and the differences between successful copers and poor copers as well as special risk subgroups among the IST children are explained. A school-based program designed to mitigate the impact of the IST experience and to demonstrate a preventive model on which other school mental health problems can be organized is presented.

748. **Rapoport, L., & Cornsweet, D.M. (1969). Preventive intervention potentials in public child care centers. *Child Welfare, 48*, 6-52.**

The Berkeley child care center is discussed. The center was designed to examine social characteristics of the population using child care services and an assessment of their mental health needs. The program has 134 boys and 118 girls. Questionnaires were sent to teachers and parents, asking about the child's initial adjustment and current behavior. The program demonstrated the usefulenss of on-the-spot, flexible, short-term intervention, especially at stressful points. Specific recommendations included having intervention in the brief transition period when a child enters child care, holding educational group meetings for mothers, and assigning a social worker to child care programs to help deal with crises and emergency situations.

749. **Rosenfeld, A., Caplan, G., Yaroslavsky, A., Jacobowitz, J., Yuval, Y., & LeBow, H. (1983). Adaptation of children of parents suffering from cancer: A preliminary study of a new field for primary prevention research. *Journal of Primary Prevention, 3*, 244-250.**

An important new field for primary prevention research is proposed: the adaptation of normal children to the stress of normal parents who suffer from cancer. A pilot retrospective investigation of adolescent daughters of mothers who had a mastectomy for breast cancer revealed a high level of motivation to participate in the study. Most girls were significantly upset and felt inadequately supported during periods of peak stress in their mothers caused by the illness and its treatment. Prospective studies are proposed that will develop and evaluate methods to ameliorate suffering and to lower the risk of psychopathology in children of parents with cancer. (Author abstract) ©Human Sciences Press.

750. **Shore, M.F., & Goldston, S.E. (1976). Mental health aspects of child hospitalization. *Journal of Pediatric Psychology, 1*, 2.**

Trends in the delivery of mental health services for hospitalized children and their continuing needs are briefly examined. Almost a decade has passed since the publication of an NIMH document designed to call attention to this area of need. Since that time, additional books have been written, new specialties have evolved, new organizations have developed, research has increased, and a new mental health-oriented children's hospital has been built. All these activities reinforce the view that concern for the mental health of children in the hospital is an exemplary opportunity to prove the feasibility of preventive child and family mental health approaches. Despite these gains, hospitals' mental health orientations in the United States still reflect inadequate training and insensitivity. Too often facilities or procedures heighten child and family anxiety, and too many hospitals still pay only lip service to mental health concepts in pediatric hospitalization.

751. **Wallinga, J.V. (1975). Comprehensive mental health planning in a children's hospital.** ***Minnesota Medicine, 58,*** **911-914.**

An innovative approach to meeting children's total emotional needs in a pediatric hospital is presented. It is contended that emotional trauma predictably occurs in children who are psychologically vulnerable because of hospitalization, illness, and surgery, and that there are many ways to prevent or minimize the effects of such experiences. Programs should incorporate special design of the physical facility, sensitivity to the feelings of siblings and parents, and emphasis on helping children anticipate their hospital experience and the aftereffects of the specific procedures that are necessary. To minimize the need for hospitalization outreach, it is felt that outpatient and short-stay programs are best. Additional services to detect and institute preventive measures or early intervention are also required. (Author abstract)

752. **Wallinga, J.V. (1979). The hospitalized child: Intervention and prevention. In I.N. Berlin & L.A. Stone (Eds.),** ***Basic handbook of child psychiatry, Vol. 4: Prevention and current issues*** **(pp. 128-135). New York: Basic Books.**

The author cites studies showing that hospitalization is invariably emotionally upsetting to children because of the stress and trauma of the event, the child's reaction to the illness, and the separation from parents. The most basic form of prevention of this problem is to avoid hospitalization unless absolutely necessary. Health care providers can play an important role in becoming sensitive to the psychological needs of children upon hospitalization. Changes in hospital policy and physical environment can provide a more sensitive and supportive climate for the mental health needs of hospitalized children. Suggestions for how a hospital should function and be designed to provide these needs are given. Traumas and reactions to hospitalization by infants, children, and adolescents are described, and ways in which a prevention program could ease the distress of the trauma of hospitalization and the distress of separation are listed. The author states that starting and sustaining an effective mental health prevention program within this area are quite difficult. Lastly, the author alludes to the possibility that the problem of trauma induced in children by hospitalization can be addressed by hospital administrators, national level medical groups, and public policymakers.

See also: 183, 215, 595, 680, 704, 792.

C. Intervention with Adults

1. Primary Prevention Following Death of a Family Member

753. **Caroff, P., & Dubrof, R. (1975). The helping process with bereaved families. In B. Schoenberg (Eds), *Bereavement: Its psychosocial aspects* (pp. 232–242). New York: Columbia University Press.**

It is suggested that, in working with bereaved families, a public health orientation that embodies concepts of primary prevention be used. This would enable caregivers to formulate broad-based programs that would support the normal process of grieving and provide for easy identification of conditions that may require a regimen of both medical and social services. It is concluded that crisis intervention has provided a conceptual model: the task for caregivers is to lend their professional expertise to designing such programs to implement this model.

754. **Conroy, R.C. (1977). Widows and widowhood. *New York State Journal of Medicine, 77*, 357–360.**

The course of grief in widowhood, and the emotional, psychiatric, health, financial, and social problems of the widow are examined. The three stages of grief (i.e., numbness, pining, and depression) are described, and it is suggested that overmedication with antidepressants and tranquilizers tends to delay and prolong the grief work. Widows and other bereaved individuals are described as typically seeking increased medical care for symptoms of anxiety, depression, and insomnia; recently bereaved widows and widowers often receive psychiatric care for the first time. Changes develop in the widow's social relationships as she adapts to the single world; she may lose essential supports in terms of money, comfort, sex, and security. It is noted that widows may reject initial contacts by outreach programs but that, as family support withers, a mental health program may be beneficial. It is concluded that the family physician's crisis intervention and knowledge of community agencies can prevent future difficulties of widowhood.

755. **Gullotta, T.P. (1982). Easing the distress of grief: A selected review of the literature with implications for prevention programs.** ***Journal of Primary Prevention, 3,*** **6–17.**

The author examines the impact death has on a spouse who has lost his mate. The current literature on grieving is examined as it applies to this group. Four tools of prevention--education, community organization, competency promotion, and natural caregiving--are explored as they might be applied to prevent the distress from loss of a spouse from causing dysfunction. Grief is seen as a natural and necessary part of life. The role of the prevention professional is to provide insurance that grief does not permanently overshadow life.

756. **Hagan, J.M. (1974). Infant death: Nursing interaction and intervention with grieving families.** ***Nursing Forum, 13,*** **371–385.**

Nursing interaction with families mourning an infant death is discussed. The fact that nursing intervention in the grief process involves all facets of the family's living is stressed. Family grief reactions to the death of an infant are described. The focus of field work with grieving families is seen to be on preventive mental health and family advocacy. The death of an infant is a special kind of loss, and the greatest need parents have is for someone who is objective and genuinely interested and who accepts grieving as a necessary process. It is felt that nurses can no longer close cases when death occurs and that they must provide care to the survivors. It is concluded that the effectiveness of nursing advocacy can be improved only when nurses examine their own avoidance of death and make the necessary philosophical and remedial changes in themselves.

757. **McCourt, W.F., Barnett, R.D., Brennen, J., & Becker, A. (1976). We help each other: Primary prevention for the widowed.** ***American Journal of Psychiatry, 133,*** **98–100.**

The inception and evolution of a program of primary prevention directed at widowed men and women is described. The program has four major components: the Widowed (telephone) Line, home visits, social gatherings, and community seminars. The various roles that the counselor plays in the program are illustrated in a case report. Results of an informal followup survey of 100 participants in the program reveal that the vast majority of those served felt the program was of benefit to them. (Author abstract)

758. **Polak, P.R., Egan, D., Vandenbergh, R., & Williams, W.V. (1975). Prevention in mental health: A controlled study.** ***American Journal of Psychiatry, 132*****, 146–149.**

Preventive intervention was examined in a controlled study in which families who had experienced the sudden death of a family member were given crisis intervention services and compared at followup with two untreated control groups. Results did not support the hypothesis that such services decrease the risk of psychiatric illnesses or the degree of disturbed family functioning. It is suggested that environmental and social systems factors are powerful predictors of outcome in bereavement.

759. **Raphael, B. (1977). Preventive intervention with the recently bereaved.** ***Archives of General Psychiatry, 34*****, 1450–1454.**

To study the effectiveness of preventive intervention in lowering postbereavement morbidity, 200 widows were assessed (demographic and background data, nature of the husband's death, quality of husband-wife relationship, and presence of concurrent crises) in the early weeks following their husbands' deaths. Ss at risk for postbereavement morbidity were selected and randomly allocated to experimental and control groups (31 and 33 Ss, respectively). Specific support for grief and encouragement of mourning were carried out with the experimental group during the first 3 months; no intervention was given to the control group. All were followed up 13 months later with a validated health questionnaire. There was a significant lowering of morbidity in the intervention group as compared to the control group. The most significant impact of intervention occurred with the subgroup of intervention Ss who perceived their social networks as very nonsupportive during the bereavement crisis. ©APA.

760. **Roskin, M. (1982). Coping with life changes: A preventive social work approach.** ***American Journal of Community Psychology, 10*****, 331–340.**

Life changes requiring substantial social readjustment were utilized to identify a population presumed to be at risk. Respondents who incurred two or more life changes––e.g., death (family member or close friend), divorce, separation, loss of work, incapacitating illness of or accident to self or close family member, imprisonment, and/or retirement––in the previous 6 weeks to 1 year and who had not received formal treatment were invited to the intervention. Intervention consisted of cognitive and affective measures utilizing didactic and small-group dynamics. Substantial verbal and nonverbal support was provided. A semi-crossover design was utilized. Less depression, anxiety, and interpersonal oversensitivity was indicated. Participants with more life changes as well as those who had experienced death in the family and/or of a close friend improved most. (Author abstract) ©Plenum Publishing Corp.

761. **Silverman, P.R. (1967). Services to the widowed: First steps in a program of preventive intervention. *Community Mental Health Journal, 3,* 37–44.**

This article describes the initial steps in developing a preventive program for widowed persons under the age of 60, a group which has been identified as having a high risk of mental illness. Various phases that one goes through after suffering a loss are described and the need for different services at each phase is indicated. The study began with an investigation of existing services for widowed individuals, and they are described along with the needs at the three phases: initial, recoil, and recovery phase. The results indicate a serious insufficiency of services for widowed individuals, particularly in the second and third phases. Alternatives to interventions provided by mental health agencies are discussed. Widowed individuals who have recovered are identified as potentially the most helpful caregivers for this particular group.

762. **Silverman, P.R. (1969). The widow to widow program: An experiment in preventive intervention. *Mental Hygiene, 53,* 333–337.**

This article describes a program designed to help widows in young families cope with the grief of the loss. Reports from many widows suggest that neither friends, family, physicians, nor clergymen were very helpful; but that other widows, because of their understanding of the situation, were. Often contact between widows would not occur without external structuring, however. The paper describes the recruitment and functioning of five widows who serve as aids to other widows. A process for contacting new widows is described, and results thus far show that almost 60 percent of those contacted have expressed interest in talking with an aide. Activities performed by the aides are described, and hopes for the future of the program are outlined. The value of locating preventive work outside of the mental health clinic and in the hands of community caregivers and self-help groups is stressed.

763. **Silverman, P.R. (1970). The widow as a caregiver in a program of preventive intervention with other widows: "I know what it is like. Let me help." *Mental Hygiene, 54,* 540–547.**

The use of a self-help group in preventive intervention is discussed. In this case, a group of widows reach out to recently widowed women and offer support in helping them adjust to their new life. This widow-to-widow program has served over 400 new widows over a 3-year period. The admission process, technique of sharing problems, reasons for effectiveness, and future of this program for prevention of emotional breakdown in a vulnerable population are discussed. (Author abstract modified)

764. **Silverman, P.R. (1970). The widow-to-widow program.** ***Archives of the Foundation of Thanatology, 2,*** **133–135.**

The Widow-to-Widow program, an experimental mental health program of preventive intervention directed at new widows and staffed by other widows, is briefly reviewed. The program is based on the belief that the best caregiver for a woman during bereavement is another widow. The five volunteer staff members, chosen for their ability to empathize and to express understanding, have contacted over 400 new widows since the program's inception. Their experience suggests that they are better able to console the new widow than are friends, family, clergy, or physicians. They also help new widows in other areas of life adjustment; such as finding employment, managing finances, establishing new social relationships, and planning future life goals.

765. **Silverman, P.R. (1972). Widowhood and preventive intervention.** ***The Family Coordinator, 21,*** **95–102.**

The author states that the transition to widowhood is largely an unrecognized problem in our society. Yet the number of widowed persons is growing, and these individuals have a high risk of developing social and emotional difficulties. The mourning process may take as long as 2 years to complete and is complicated by the individual's sudden transition in social role, from wife or husband to single individual. One's relations with other people and with one's self are suddenly transformed. The Widow-to-Widow program, developed in response to the needs of the bereaved, attempting to reach all the widowed women under the age of 60 in a community, is described. The counselors in the program were themselves widows who had gone through this experience. This facilitated the rapid development of a trusting relationship, which provided considerable support for new widows attempting to cope with their grief. The widow aides also served as role models and as a sort of "bridge person," helping the recently widowed woman to move from her social isolation to a more active social role. The author believes that these measures are very important in preventing mental disorders due to bereavement.

766. **Silverman, P.R. (1973). *Widow-tc-Widow program*. New York: Health Sciences.**

A service designed to ease the distress and grief of widows and lessen the possibility of their developing emotional and psychiatric disorders is outlined. The program described was initiated by the Laboratory for Community Psychiatry of Harvard Medical School as a model preventive intervention project, based on the premise that the best caregiver for a widow during the period of bereavement is another widow. The therapeutic effect of a widow's contact with another woman who has overcome the emotional problems of the loss of a spouse, and who has successfully made the adjustments to the problems implicit in the widowed state, is explored.

767. **Silverman, P.R., & Murrow, H.G. (1976). Mutual help during critical role transitions. *Journal of Applied Behavioral Science, 12*, 410-418.**

This paper describes the use of mutual help groups as a means of delivering the most appropriate help possible to populations at risk in a timely and efficient manner in order to prevent emotional difficulties. The authors look at prevention in terms of programs that will promote a target group's ability to cope successfully with the changes, crises, and transitions of their lives. It is suggested that the Widow-to-Widow programs and La Leche groups may offer examples of services that are preventive and that could be replicated for other groups or crisis points. The lack of opportunity to learn to differentiate between roles and to move from one role to the other in orderly fashion is seen as detrimental to one's mental health. Mutual help groups are seen as aids to facilitate these transitions. Finally, the authors look at crisis theory, the way in which the model programs deal with the crisis, and the "natural history" of crises. They discuss the roles of care- givers or professionals in referring to and aiding the various types of self-help programs.

768. **Silverman, P.R. (1977). Mutual help groups for the widowed. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 76-78). (DHEW Pub. No. (ADM) 77-447). Washington, DC: U.S. Government Printing Office.**

The role of the mental health professional in the development of mutual help groups for the widowed, designed to facilitate the bereavement process and the transition to future orientation and new identity development, is summarized. The bereavement process and subsequent role redefinition and adjustment are discussed. The mental health professional may involve himself in mutual help groups targeted for the widowed through group referral, group consultation, or group development. Procedures for establishing a new mutual help program include: (1) forming a group of interested and involved helpers, (2) deciding upon sponsorship, (3) engaging in public relations and community education, (4) establishing program goals, and (5) orienting volunteers and providing consultation.

769. **Williams, V.V., Lee, J., & Polak, P.R. (1976). Crisis intervention: Effects of crisis intervention on family survivors of sudden death situations. *Community Mental Health Journal, 12*, 128–136.**

A controlled study that examined the effects of a short-term crisis service given to a group of families recently bereaved through a sudden death within the family is reported. The results reveal that sudden death does have major impact on recently bereaved families in terms of increased risk of ill health, poor coping behavior, and disturbed social functioning when compared to nonbereaved families. However, the short-term crisis service appeared to have no major impact on postbereavement adjustment. Discussion centered around possible reasons for failure of the short-term crisis services.

770. **Williams, V.V., & Polak, P.R. (1979). Follow-up research in primary prevention: A model of adjustment in acute grief. *Journal of Clinical Psychology, 35*, 35–45.**

The authors investigated the effects of preventive intervention that followed the life crisis of sudden death in the family. Two bereaved groups of families (one of which received preventive intervention service), and one nonbereaved group, were compared in an outcome design and were assessed for indices of illness, psychosocial disturbance, and general quality of life. Results show that sudden death has a two-stage impact on family survivors and that subsequent adjustment can be predicted from a knowledge of facts at the time of death. A preventive intervention service had little or no impact and may have been harmful. Discussion centers on possible intervention strategies focusing on the complex determinants of environmental stresses and family/individual variables. ©APA.

See also: 247, 683, 708, 727, 812, 929, 997.

771. **Bloom, B.L. (1978). Marital disruption as a stressor. In D.G. Forgays (Ed.), *Primary prevention of psychopathology, Vol. 2: Environmental influences* (pp. 81–105). Hanover, NH: University Press of New England.**

It is suggested that the past decade or two has witnessed a movement away from considerations of predisposing factors in mental illnesses toward concern with precipitating and perpetuating factors. There is a growing body of research showing that marital disruption often constitutes severe stress, the consequences of which can be seen in a surprisingly wide variety of physical and emotional disorders. Persons undergoing marital disruption have been shown to be at higher risk for psychiatric disorders, suicide, homocide, motor vehicle accidents, and a variety of forms of disease morbidity and disease mortality. Hypotheses that have been advanced to account for the associations found between marital disruption and various physical and emotional disorders are discussed.

772. **Bloom, B.L., Hodges, W.F., & Caldwell, R.A. (1982). A preventive program for the newly separated: Initial evaluation. *American Journal of Community Psychology, 10*, 257–264.**

The article describes the development of a 6-month preventive-intervention program for newly separated persons, designed on the basis of a literature analysis that identified the major stressful elements in the separation experience. The program's impact was assessed by contrasting 100 persons who were assigned to the program with 50 newly separated persons who were randomly selected to serve as a no-treatment control group. Interviews were conducted with all Ss at the beginning of the study and 6, 18, and 30 months later. The intervention program included assignment to a representative who played an active outreach role, and the availability of study groups on employment, childrearing, finances, homemaking, and socialization. Of the nine dependent measures of adjustment used, five significant posttreatment differences were found, in each case favoring the intervention group. Members of the intervention group also showed a significant decrease in general psychological problems across time. The nature of these differences is encouraging in light of the preventively oriented objectives of the intervention program. ©APA.

773. **Jacobson, G.F., & Portuges, S.H. (1976). Marital separation and divorce—assessment of and preventive considerations for crisis intervention. In H.J. Parad, H.L.P. Resnik, & L.G. Parad (Eds.), *Emergency and disaster management* (pp. 433–441). Bowie, MD: Charles Press.**

According to crisis theory, crisis follows a hazard that represents a significant loss or threat of loss. It therefore seems reasonable to expect that a significant number of individuals who use the services of crisis intervention clinics are involved in marital separation or divorce. In the marital dissolution process, several naturally occurring events may precipitate a crisis: (a) the first serious mention of separation, (b) the actual separation, and (c) the final divorce decree. Poor resolution of any one of these crises may lead to psychiatric impairment. The role of the intervenor is clearly to aid persons in finding adaptive resolutions to these problems. A synopsis of preventive intervention strategies with persons in the process of marital dissolution and in the period after divorce is presented. Each strategy entailed identifying the threat involved, being aware of possible outcomes and their different advantages and disadvantages, clarifying to the person what his previous coping had been and why it failed, working through grief if separation or divorce does occur, and developing new coping mechanisms.

See also: 183, 588, 760, 812, 819, 929.

3. Primary Prevention Following Other Stressful Life Events

774. **Barton, D., & Abram, H.S. (1971). Preventive psychiatry in the general hospital. *Comprehensive Psychiatry, 12,* 330–336.**

An overview of the role of preventive psychiatry in the general hospital is presented. The need for the hospital to avoid adaptive failure through increased awareness of the emotional needs of patients and staff is noted. Primary prevention in the general hospital or the reduction of the incidence of psychosocial adaptive failure and mental disorder involves: (1) the recognition and reduction of psychological stresses resulting from the hospital setting and illness; (2) the recognition of personality traits and other predisposing factors in the individual's environment that render him/her vulnerable to psychosocial adaptive failure during the course of hospitalization and illness; (3) the appreciation of interactional patterns between the patient and those taking care of him; (4) the recognition and strengthening of those factors in the doctor-patient relationship, nurse-patient relationship, and general hospital environment that support the individual's adaptive abilities; and (5) appreciation of those disorders resulting in organic dysfunction that predispose the individual to adaptive failure.

775. **Bloom, B.L. (1971). A university freshman preventive intervention program: Report of a pilot project. *Journal of Consulting and Clinical Psychology, 37*, 235–242.**

A preventive intervention program with university freshmen is described and evaluated. This project had as its objectives the development of greater emotional maturity, more successful adaptation to the college community, less psychological disability, and fewer dropouts. By means of an interactive process using special questionnaires that were distributed and analyzed, the participating students were provided with membership in a group that had psychological reality, were given some reference facts with which to compare themselves, and were given some intellectual tools by which they might better understand the stresses acting on them and their reactions to these stresses. Evaluation of the pilot project was generally favorable, although differences between the experimental and a comparison group were not large even when statistically significant. Suggestions for an improved program are given. (Author abstract) ©APA.

776. **Borus, J.F. (1973). Reentry II: "Making it" back in the States. *American Journal of Psychiatry, 130*, 850–854.**

Differential characteristics, adjustment stresses, and coping methods of three groups of successful and unsuccessful Vietnam veterans attempting to adjust to life in the U.S. are defined. Findings suggest the need for preventive intervention programs to facilitate the successful readjustment of these veterans. It is suggested that such programs should focus on decreasing unnecessary stresses in the readjustment process, better preparing returnees for adjustment issues, and increasing the variety of coping methods available to them. (Author abstract modified)

777. **Borus, J.F. (1973). Reentry III: Facilitating health readjustment in Vietnam veterans. *Psychiatry, 36*, 428–439.**

Vietnam veteran studies are integrated with World War II veteran studies, principles of military psychiatry, and civilian studies of coping with stressful transitions. Suggestions for military primary prevention programs to facilitate healthy readjustment in returning combat veterans are also presented. The issues of military, family, emotional, and social adjustment are compared in the two wars. A model program for preventive intervention is described providing speculated outcomes and program costs.

778. **Brody, E.B. (1969). Preventive planning and strategies of intervention. *American Behavioral Scientist, 13,* 126–132.**

Preventive planning may be aimed at "the individual migrant, the donor society, or the host society during any phase of the migratory process including the transitional." Using migration of persons from and into new geographical areas as an example, the author first discusses how public policy initiatives that facilitate or prevent the movement of people lead to predictable consequences, both positive and negative. He then discusses potential individual and group interventions that are designed to aid the successful transition of the migrant from one set of circumstances to another. Individual interventions include such possibilities as a comprehensive "gateway center" that can provide resources and information to the migrant, while group interventions focus more on organizing migrants into developing structures that facilitate their stability and survival. The issue of involuntary as well as voluntary migration is also mentioned.

779. **Conyne, R.K. (1983). Two critical issues in primary prevention: What it is and how to do it. *Personnel and Guidance Journal, 61,* 331–334.**

The author discusses primary prevention of mental health disturbances in colleges. Primary prevention has two goals: to reduce the incidence of emotional stress and to promote emotional robustness. Directions from public health, end-state, and stressful life variable models, assessment of populations at risk, and primary prevention program components are discussed. End state refers to states to be prevented such as drug abuse or suicide; stressful life variables refer to factors that may precipitate such end states, such as not making friends or a competitive academic environment. ©APA.

780. **Keepes, B. (1977). The University of Evansville takes advantage of preventive action for mental health. *College Student Journal, 11,* 36–42.**

The author considers preventive measures that can be taken against student emotional difficulties arising from life on the college campus. Facilities on several campuses are reviewed, with concentration on those aspects applicable to the University of Evansville, and recommendations are made for a facility specifically designed to operate on its campus. ©APA.

781. **Kirshner, L.A. (1974). A follow-up of a freshmen group counseling program.** ***Journal of the American College Health Association, 22,*** **279-280.**

A freshmen group counseling program at Harvard University was assessed to determine participant motivation, needs, and subjective benefits. The extent of more serious psychopathology was also studied. Results of the volunteer program indicate participant interest in therapy and/or experience of college adjustment difficulties. It is concluded that the freshman program is a helpful preventive measure for a psychiatrically vulnerable population.

782. **Lazarus, H.R., & Hagens, J.H. (1968). Prevention of psychosis following open-heart surgery.** ***American Journal of Psychiatry, 124,*** **1190-1195.**

The high risk of postoperative psychotic reaction occurring in patients who have undergone open-heart surgery has been attributed to several factors. The authors studied two of these--preoperative psychological state of the patient and environment in the recovery room--to determine their influence upon the incidence of postoperative reactions in two groups of heart-surgery patients. They conclude that a preoperative psychiatric interview, accompanied by individual recommendations for postoperative care, and minimization of the environmental stresses of the recovery room, lessen the risk of postoperative psychotic reaction among heart-surgery patients. (Author abstract)

783. **Lindquist, C.U., & Lowe, S.R. (1978). A community-oriented evaluation of two prevention programs for college freshmen.** ***Journal of Counseling Psychology, 25,*** **53-60.**

Two preventive interventions aimed at reducing the stress of the first year of college for freshmen were evaluated. The cohort program, a written interactive program, was compared to a peer-led group program with respect to possible impact on the college freshman population with regard to their use of available resources in the campus community and in terms of their effectiveness as measured by traditional questionnaires. The programs were found to differ in the type of students they attracted, with the cohort program attracting more nonusers of traditional services and the group program attracting those who would otherwise use traditional services. While both the programs were seen as effective by their respective participants, neither treatment was effective in reducing dropout rate or improving grade point average. Results are discussed both in terms of the treatment impact on the individuals participating and in terms of program impact on freshman population experiencing psychological stress in their first year of school. (Author abstract)

784. **Morschauser, E.J., & Cheschelr, M.W. (1982). Identity and community relocation. *Social Casework, 63,* 554–560.**

This article presents a prevention model designed to assist individuals and families during the process of relocating to a new community. The model employs a combined educational/therapeutic approach that emphasizes primary prevention through the development of coping skills, community networks, and individual autonomy. The individual is viewed as competent to analyze his/her own needs and make the best decisions based on self-recognition of needs and objectives. The model assists the individual through this difficult process but does not act as a surrogate. Approached in this fashion, the individual can absorb the information presented and the feelings associated with relocation into his/her total life experience in a way that will facilitate growth and feelings of self-worth and competence. ©APA.

785. **Rose, J.A. (1961). The prevention of mothering breakdown associated with physical abnormalities of the infant. In G. Caplan (Ed.), *Prevention of mental disorders in children* (pp. 265–282). New York: Basic Books.**

It is hypothesized that the loss associated with an infant who has a health defect, as well as other critical maternal losses occurring in the prenatal or early postnatal periods, is commonly related to object loss phenomena recapitulated in the mother's maturational crises and leads to pathogenic mother-infant interaction. A planned study to test this hypothesis and to evaluate the impact of specific maternal behaviors on the child at different maturational periods is presented. It is thought that early, repeated contact with resident pediatricians, as well as other support, could be effective in preventing the occurrence of a pathological reaction to loss.

786. **Signell, K.A. (1972). Kindergarten entry: A preventive approach to community mental health. *Community Mental Health Journal, 8,* 60–70.**

Small group discussions with parents at kindergarten entry time are presented as a model of preventive mental health. The aim was education for a population, not screening. The group discussion process was crisis focused, not pathology centered. Clinical techniques are presented for providing anticipatory guidance and resolution of separation reactions. The program also explored developing the natural resource of experienced mothers in the community for crisis intervention. (Author abstract) ©Human Sciences Press.

787. **Sluzki, C.E. (1979). Migration and family conflict. *Family Process, 18*, 379–390.**

Stages in the process of migration are described, and the implications of each stage for family conflict and for appropriate therapeutic intervention are discussed. It is contended that the migratory process can be described in relatively culture-free terms and that there are specific stresses associated with different aspects of the migratory process. Stages of the migratory process are: the preparatory stage, the act of migration, the period of overcompensation, the period of decompensation or crisis, and the transgenerational impact of migration. Preventive and therapeutic implications of the model of the migratory process are discussed.

See also: 183, 215, 595, 658, 927.

XIII. Primary Prevention and Social Support

Social support as a variable affecting the mental health of individuals is a subject of much attention within the mental health field. The use of the social support variable in preventive interventions has been discussed as well as implemented. Articles in this section are divided into two categories. The first includes articles that provide reviews, conceptualizations, or descriptions of prevention programs involving social support. The second section is made up of articles describing the use of self-help groups. Members of such groups provide dialogue, information, and social support to one another. Participation in such groups can constitute a means of prevention or a means of mental health promotion.

A. Reviews, Conceptual Discussions, and Descriptions of Preventive Programs Involving Social Support

788. **Barrera, Jr., M., & Balls, P. (1983). Assessing social support as a prevention resource: An illustrative study. *Prevention in Human Services, 2*, 59–74.**

Social support is popularly regarded as a naturally existing resource that acts to prevent disorder by buffering the effects of stress or by meeting individuals' fundamental needs for meaningful human attachment. The present paper begins by discussing approaches to measuring social support that might be adopted in needs assessment research. A prospective study of 74 young mothers is described to illustrate the use of multiple measures of support in investigating their relationship to birth outcome measures. In this study, direct relationships were found between birth outcome indices and measures of both prenatal negative life events and psychological distress. Social support network size showed stress moderating effects when Apgar scores served as the outcome measure. When the presence of birth complications served as the criterion variable, moderating effects were also found for a support satisfaction measure. The paper closes by examining some implications of this study for needs assessments designed for the planning of preventive interventions. (Author abstract) ©The Haworth Press.

789. **Budman, S. H. (1975). A strategy for preventive mental health intervention. *Professional Psychology, 6*, 394-398.**

A model for developing a socially supportive structure to aid families during predictable life crises is described. This model, the "psychoeducational group," is appropriate for use with many different at-risk populations such as veterans, new parents, or people with similar medical problems. The stages of group life are described, along with the role of the leader in such groups. Group members provide one another with information and emotional support for coping with life problems.

790. **Caplan, G. (1973). *Support systems and community mental health: Lectures on concept development*. New York: Behavioral Publications.**

Population-oriented preventive psychiatry is discussed, based on clinical and experimental research. The importance of structuring cognitive and emotional supports for people in difficulty is emphasized. Other areas covered include how to detect the early stages of mental disturbance in children, the role of the social worker in preventive psychiatry, and conceptual models in community mental health.

791. **Cassel, J. (1973). The relation of the urban environment to health: Implications for prevention. *Mount Sinai Journal of Medicine, 40*, 539-550.**

Prevention of disease has been most successful when the environmental factors facilitating its occurrence have been dealt with. Turning his attention to the relationship between disease and lower-class urban living conditions, the author draws from the findings of animal research to advance four general hypotheses: (1) The relationship between population density and enhanced susceptibility to disease is due more to disturbed social relationships than to crowding per se. (2) Members of a given population are differentially susceptible to the effects of social processes associated with disease. (3) Certain biological and social adaptive processes may be protective. (4) Variations in group relationships interact with such factors as genetic predisposition and the nature of the physicochemical or microbiological insults to the organism to bring about changes in health. This conceptualization of the problem suggests that efforts at primary prevention should focus on attempts to modify adverse psychosocial factors and to strengthen social supports.

792. **Felner, R.D., Ginter, M., & Primavera, J. (1982). Primary prevention during school transitions: Social support and environmental structure. *American Journal of Community Psychology, 10*, 277-290.**

This article discusses the nature and evaluation of a primary prevention project for students during the transition to high school. The project sought to increase the level of social support available and to reduce the degree of flux and complexity in the school setting. Midyear and end-of-ninth-grade assessments were done on 59 project and 113 matched control students' self-concepts, their perceptions of the school environment, and their eighth- and ninth-grade attendance and grades. The project had two primary components: (a) restructuring the role of homeroom teachers so that they acted more as counselors and liaisons, and (b) reorganizing class schedules so that Ss had more classes together and had more teachers in common. By the end of ninth grade, project Ss showed significantly better attendance records and GPA, as well as more stable self-concepts than controls. By the final evaluation point, project Ss also reported perceiving the school environment as having greater clarity of expectations and organizational structure and higher levels of teacher support and involvement than did nonproject Ss. ©APA.

793. **Gottlieb, B.H. (1975). The contribution of natural support systems to primary prevention among four social subgroups of adolescent males. *Adolescence, 10*, 207-220.**

The author examines natural support systems and assesses how the coping efforts of adolescents are strengthened by helping relationships with informal community resources. The four subgroups are elites, isolates, deviants, and outsiders. Private interviews were conducted with five youths from each subgroup. The major problems and preferred help sources of each subgroup are discussed. The cultural environment of each mediates both the particular stresses that members experience and their access to and preference for different helping agents. ©APA.

794. **Gottlieb, B.H. (1979). The primary group as supportive milieu: Applications to community psychology. *American Journal of Community Psychology, 7,* 469–480.**

The author reviews evidence documenting the health-protective effects of the informal social support extended by kith, kin, and community gatekeepers. Features of a classification scheme describing the substance of informal helping behaviors are outlined. Implications for future research and action address (a) the need for professionals to reexamine occasions for the provision of consultation and crisis-intervention services; (b) the potential for using social network analysis to identify vulnerable groups in the community; and (c) the merits of advocating informal support systems as favorable settings for the accomplishment of primary prevention. ©APA.

795. **Gottlieb, B.H., & Hall, A. (1980). Social networks and the utilization of preventive mental health services. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 167–194). Beverly Hills: Sage.**

Detailed attention is given to three ways in which social networks might have an impact on the utilization of treatment and preventive services. Social networks may act as communication systems, referral systems, and support systems. The structure of those networks may impact on how effectively they serve those three functions. First, as communication systems, a network composed of people who participate in varied social settings provides a diversity of information. Further, those with access to information must pass it on to those members without such access. Secondly, as referral systems, individuals often turn to network members for advice and feedback about the costs and benefits of different services. Lastly, as support systems, networks may meet peoples' needs for help and guidance directly, reducing the likelihood that people will seek outside help. Implications for designing and implementing services are discussed.

796. **Gottlieb, B.H. (1981). Preventive interventions involving social networks and social support. In B.H. Gottlieb (Ed.), *Social networks and social support* (pp. 201–232). Beverly Hills: Sage.**

This article briefly discusses the literature on social support and social networks. The author discusses two different approaches that have been used concerning social networks and the design of preventive interventions. One approach focuses on the design of preventive interventions that aim to restructure social networks in a general population to enhance people's access to supportive social ties, or to boost the quality of support from people's existing ties. A second preventive approach entails working with individuals who are at high risk to develop psychopathology; specifically, those individuals who have undergone a life crisis or stressful transition that may include the death of a spouse, separation, divorce, geographic move, or retirement. The author reviews and critiques two types of planned interventions designed to improve the quality of social support available to people: (1) interventions aimed at improving the quality of support expressed within existing dyads, and (2) interventions at heightening the importance of new or existing social ties. The author emphasizes the importance of analyzing the individual's social networks as a means of understanding the nature and quality of his or her social support.

797. Gottlieb, B.H. (1983). *Social support strategies.* Beverly Hills: Sage.

This is a comprehensive 220-page book on social support in mental health. It describes early theoretical formulations, basic research, and specific applications regarding social support. Contained within the book is a chapter on social support related to preventive interventions. Examples of primary and secondary preventive interventions are divided into two types. The first type involves the formation of social support groups for individuals who share in common a recent stressful life event such as divorce or bereavement or a community level disaster such as an airline crash or life transition. Some of the advantages of such groups are discussed as well as problems that are encountered such as underutilization by the poor and by males. A second class of preventive interventions involves the optimization of social support. These interventions aim to restructure individuals' networks or improve their helping processes in order to increase their access to social support. These interventions are not built around the notion of helping people cope with stressful events but are designed to enhance the networks of individuals who have marginal social support. Preventive interventions of this type involve improving the skills of professionals such as lawyers, hairdressers, physicians, and clergymen in providing support and communication. Improving the social support of elderly and minority populations is also briefly discussed in the chapter.

798. **Haggerty, R.J. (1980). Life stress, illness and social supports. *Developmental Medicine and Child Neurology, 22*, 391–400.**

The literature concerning the relationship between life stress and etiology of disease is briefly reviewed, the role of stress in determining use of health services by families is demonstrated, and public health implications of the moderating influence of social supports on the stress/illness relationship are discussed. It is noted that stress has been shown to lower resistance to disease and to be associated with use of medical services. Social support (e.g., a caring family) seems to be an important factor mediating the effects of stress. Given their importance in preventive medicine, it is suggested that social support systems should play an increasing part in health services.

799. **Heller, K., & Swindle, R.W. (1983). Social networks, perceived social support, and coping with stress. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 87–103). New York: Pergamon Press.**

In a review of the literature on the relationship between stress and social support, the authors present its historical roots in social psychology and sociology, the major guiding hypothesis about the stress-buffering effects of social support, and a proposed model linking social support and coping. This model distinguishes between social networks, perceived social support, and support seeking and incorporates person-variables with regard to coping style. The current state of research in this area suffers from lack of clear distinctions among these different processes and confusion between dependent and independent variables. While still maintaining the importance of social support in coping with life stress and the value of interventions to enhance support for individuals in distress, the need for clearer conceptual and methodological work is emphasized.

800. **Kagey, J.R., Vivace, J., & Lutz, W. (1981). Mental health primary prevention: The role of parent mutual support groups. *American Journal of Public Health, 71*,** 166–167.

A primary prevention program developed to provide supportive services for parents of newborns is described, and parents' reactions to the mutual support groups are evaluated. Ninety-eight parents responded to a survey intended to evaluate what the groups provided. Parents evaluated the groups as effective in providing social contact, supporting the parenting role, helping parents feel less alone, promoting an understanding of children's development, and increasing child care skills. The parents did not evaluate the groups as helping to improve a relationship with their spouse. (Author abstract modified)

801. **McGuire, J.C., & Gottlieb, B.H. (1979). Social support groups among new parents: An experimental study in primary prevention. *Journal of Clinical Child Psychology, 8,* 111–116.**

This article reports the findings of an action-research project aimed at assessing the health-protective effects and social consequences arising from the creation of social support groups among new parents. The study was designed and implemented in collaboration with two family physicians and adopted an experimental design whereby new parents from each physician's files were randomly assigned to a treatment (social support) group and a control (written educational materials only) group. Twenty-four couples completed questionnaires inquiring about their use of informal social support, their levels of stress and well-being, and their perceptions of their own parenting role both before attending the group sessions and 5 weeks after the final session. Analysis of covariance revealed that the intervention prompted couples to increase their use of informal resources in their own social networks, while it did not alter levels of stress or well-being. Discussion centers on methodological issues related to the measurement of positive health states in primary preventive studies, and it addresses the practical implications of the current investigation for future efforts to mobilize informal social support on behalf of persons undergoing potentially stressful life transitions. ©APA.

802. **Mitchell, R.E., Billings, A.G., & Moos, R.H. (1982). Social support and well-being: Implications for prevention programs. *Journal of Primary Prevention, 3,* 77–98.**

A variety of prevention programs have assumed that social support has health-promotive and health-protective effects. Although numerous studies have examined the relationship between social support and well-being, the result has been a heterogeneous and complex set of findings. The authors seek to review and summarize this research as a data base for planning and evaluating prevention programs. To organize the review, they present a model of stress, support, and well-being that distinguishes among several mechanisms through which support may affect well-being. The authors consider research on each of these mechanisms: the direct effects of support upon functioning; the indirect effects of support upon functioning through its influence on exposure to environmental stressors; and the interactive effects of social support in buffering the individual from the maladaptive effects of stress. We then address several implications of this research that need to be considered in the process of designing and evaluating prevention programs: (a) the need to consider the varying mechanisms through which social support has its effects; (b) the need for specificity in developing preventive interventions; and (c) the need to examine relationships among stress, support, and functioning within a broader social context. (Author abstract) ©Human Sciences Press.

803. **Wandersman, L.P. (1982). An analysis of the effectiveness of parent-infant support groups.** ***Journal of Primary Prevention, 3,*** **99-115.**

A variety of programs have been developed to provide support and education for new parents. This article analyzes underlying issues in, and common problems of, parent-infant support groups. The Family Development Parenting Groups are described to illustrate typical findings of very positive feelings of participants toward the groups but few objective effects of participation on adjustment or family functioning. The analysis suggests the importance of coordinating the type of goals of the program with (a) the needs of participants, (b) the implementation strategies, and (c) the measurement of positive and negative effects. The need to clarify the operationalization of support and to specifically measure the behavioral processes and effects of support is emphasized. (Author abstract) ©Human Sciences Press.

See also: 20, 21, 303, 355, 550, 562, 566, 581, 605, 623, 629, 640, 651, 652, 653, 666, 684, 714, 759, 775, 808, 819, 843, 877, 908, 1003, 1005.

B. Self-Help Groups

804. **Borck, L.E., & Aronowitz, E. (1982). The role of a self-help clearinghouse.** ***Journal of Prevention in Human Services, 1,*** **121-129.**

As self-help groups continue to proliferate, the formation of an umbrella body is suggested. A Self-Help Clearinghouse would serve as such an umbrella through the establishment of an information, referral, and research service for mutual aid groups in a given area. It would also be available to offer technical assistance to existing groups and assistance in the formation of new self-help groups. As a prevention service, it could be integrated into a comprehensive community mental health service system or operated under other auspices. In either case, it is a barometer of community stressors and offers great promise in strengthening social supports, coping skills, and competence provided by self-help groups. (Author abstract) ©The Haworth Press.

805. **Borman, L.D. (1982). Helping people to help themselves—self-help and prevention: Introduction. *Prevention in Human Services, 1,* 3–15.**

The author considers self-help/mutual aid groups in the light of five criteria outlined by the Task Panel on Prevention of the President's Commission on Mental Health: (1) paradigm shift in human services, (2) proactive approach to strengthening adaptive capacity, (3) focus on total populations, (4) articulation with existing delivery systems, and (5) strategy founded on increasing knowledge base. A model of self-help group roles in prevention is presented. ©APA.

806. **Davis, M.S. (1977). Women's liberation groups as primary preventive mental health strategy. *Community Mental Health Journal, 13,* 219–228.**

The efficacy of a women's liberation group as a primary preventive mental health agent is discussed in reference to "Ms. Pacifica," an informal women's group in suburban San Francisco that included a community mental health worker. It was speculated that, given the group's emphasis on consciousness raising, women's issues, legal rights, employment, and the general status of women, welfare, and sexuality, it would promote both women's equality and primary prevention. The mental health care worker was concerned with countering the sense of isolation and powerlessness prevalent among women in suburban areas. Subsequent investigation and observations bore out the expectation that many of the goals, premises, and methods of preventive mental health were compatible with those of women's liberation groups, and that such groups are effective from both a feminist and primary prevention standpoint.

807. **Gartner, A., & Riessman, F. (1977). *Self-help in the human services.* San Francisco: Jossey Bass.**

A comprehensive review of the development, dynamics, and contributions of the self-help movement and mutual aid programs to the field of human service delivery is presented. The rise of the self-help movement as a response to outmoded professional models, ineffective service delivery, and unmet needs, is discussed; and the present status and future directions of the movement are reviewed. Mutual aid groups in the mental health field are described; and detailed information about health programs devoted to rehabilitation, behavior modificaiton, primary care, and preventive care is provided. The dynamics of personal involvement in the helping process are examined within the context of self-help program effectiveness. New forms and new styles of self-help programs that incorporate professionals as organizers or sponsors are recommended, particularly in the delivery of services to the aged, the poor, and minority groups. A directory of 130 self-help groups is given. Also included is an extensive and detailed comparison of conventional psychotherapy and peer self-help therapy.

808. Gartner, A.J., & Riessman, F. (1982). Self-help and mental Health. *Hospital and Community Psychiatry, 33*, 631-635.

Over the past decade self-help groups have become an important way of helping people cope with various life crises. Groups have organized to help individual members deal with a wide range of health-related and other problems. The authors define the meaning of self-help in such groups and describe the range of groups now available, including a number of mental health-related groups. The part self-help groups play in providing social support, preventing illness and death, and reducing the need for hospitalization is discussed. The authors also examine the role of professionals in initiating and working with such groups. They point to self-help groups as one means of meeting the increasing demands placed on health and mental health service systems during the 1980s. (Author abstract)

809. **Hermalin, J., Melendez, L., Kamarch, T., Klevans, F., Ballen, E., & Gordon, M. (1979). Enhancing primary prevention: The marriage of self-help groups and formal health care delivery systems. *Journal of Clinical Child Psychology, 8*, 125-129.**

A working relationship between formal health care delivery systems and community-based self-help groups is frequently advocated as a primary prevention strategy for children as well as adults. To develop and implement such a strategy involves understanding of (a) interorganizational awareness, (b) interaction patterns, and (c) attitudes toward future involvement. In the first known study of its type, the 74 clinical staff members of a large urban community mental health/mental retardation center were queried about their involvement with self-help groups on these three issues. Results of the survey indicate overwhelmingly that clinicians desired community mental health centers to become involved with self-help groups. A need for greater awareness of self-help groups was also indicated. ©APA.

810. **Robinson, D. (1980). The self-help component of primary health care. *Social Science and Medicine, 14*,** 415-421.

Issues related to the self-help component of primary health care are discussed with reference to the World Health Organization goal of "health for all by the year 2000." The importance of recognizing that a large proportion of preventive, promotive, and curative procedures do not require extensive medical training, and implementation of a primary health care philosophy that recognizes that physical, mental, and social well-being depends on the active involvement of the individual and the community are emphasized. The characteristics of self-help groups, their aims, and their strategies, are reviewed; and identification of problems for self-help intervention in developed and developing nations is discussed. Once the problem has been identified, the self-help process requires a dissemination of information and sharing of techniques. Destigmatization is another important function of self-help groups. Finally, the group serves as a mutual source of support and resources for those sharing a common problem; activities and projects encourage self-development and enable members to influence the quality of their everyday lives. (Author abstract modified)

811. **Romeder, J. (1981). Self-help groups and mental health: A promising avenue. *Canada's Mental Health, 29*, 10-12, 31-32**

The benefits of self-help groups and the needs they meet in contemporary society are discussed. Self-help groups are defined as voluntary, small group structures for mutual aid and the accomplishment of a special purpose, formed by peers for mutual assistance. Eight major categories of self-help groups, differentiated according to the problems they address, are described. Self-help groups are seen as a powerful means of prevention in that they allow reduction of the risks of illness resulting from exposure to stressful psychosocial processes associated with various crises or difficult situations.

812. **Schwartz, M.D. (1975). Situation/transition groups: A conceptualization and review. *American Journal of Orthopsychiatry, 45*, 744-755.**

Literature concerning a broad range of Situation/Transition (S/T) groups is reviewed. Five characteristics common to S/T groups and the two kinds of assistance that they are most frequently reported to offer are identified. These small discussion/education groups, moderated by a trained leader, have been used in a variety of settings for the mutual assistance of individuals who share some stressful life situations, including medical problems, parenting, marital disruption, job stress, and maturational crises. The problem of leadership and other hazards endemic to the group process are discussed. The situation group is seen as being an important primary preventive approach for both mental and physical health problems. (Author abstract modified)

813. Silverman, P.R. (1978). ***Mutual help groups: A guide for mental health workers*** **(DHHS Pub. No. (ADM) 80-646). Washington, DC: U.S. Government Printing Office.**

This 60-page monograph defines and discusses mutual help groups. Also included is a discussion of the characteristics and nature of the help provided, what specific mutual help groups do, and the role of the mental health worker with mutual help groups. A bibliography contained at the end provides references to literature related to this topic.

See also: 422, 532, 579, 595, 619, 641, 658, 721, 763, 767, 768, 789, 843.

XIV. Environmental Perspectives on Primary Prevention

Changing an aspect of the environment or social system within which a group of individuals is embedded is a frequently discussed strategy of primary prevention of psychopathology. Such changes might involve an improvement in an environment affecting a limited number of individuals or could involve change in a social policy or broad economic system that would influence the lives of a large number of people.

Articles are divided into three sections. The first section includes articles that propose changes in certain environments, provide reviews and conceptual discussions of this strategy of prevention, or describe preventive interventions involving change in some physical environment. In the second section, broad social change in the economic or governmental system is proposed as being a viable means of primary prevention of psychopathology. Other articles in this section discuss the results of broad social change on psychopathology or are concerned with issues related to this strategy of primary prevention. Articles in the third section describe interventions aimed at improving and developing resources in a neighborhood or geographic community in such a way that the changes might have preventive ramifications for the residents.

A. Changing Environments

814. **Akabas, S.H. (1982). The world of work: A site for mental health promotion. In F. D. Perlmutter (Ed.), *New directions for mental health services: Mental health promotion and primary prevention* (pp. 33–44). San Francisco: Jossey Bass.**

Reasons why work, work organizations, and the workplace have been absent from mental health literature until recently are addressed. Promising programs that have been developed, and the potential contribution of work and the worksite to mental health promotion in American society, also are reviewed. Changing realities have supported mental health programs in the workplace, and workers' reluctance no longer obstructs their development. Mental health care generally is viewed with less fear of stigma, with modern day workers more likely to attribute life's problems to psychological causes than their predecessors. By offering a climate that fosters personal and social growth, the workplace can serve as a developmental institution. Viewing the workplace as a community allows mental health providers to ask how they can modify the system of the workplace to enable it to serve its community function better. The workplace is an environment that can be organized to emphasize individual adaptation and coping, and it provides another way in which mental health may be promoted. The issues of auspices, confidentiality, and cost effectiveness are raised by three exemplary programs in the workplace.

815. **Forgays, D.G. (Ed.) (1978). *Primary prevention of psychopathology, Vol. 2: Environmental influences*. Hanover, NH: University Press of New England.**

The proceedings of a 1976 conference on environmental influences that contribute to, and environmental interventions that may prevent, the development of psychopathology are presented. Part 1 defines positive mental health, clarifies the scope of primary prevention, and summarizes Federal contributions in the area. Part 2 examines research approaches in primary prevention. Part 3 presents theoretical approaches to mental health, such as the individual model of social change versus the environmental model, and a conceptual analysis of privacy as a social systems concept. Part 4 explores environmental psychology and prevention. In the last section, a summary is presented and the conference is evaluated. The report of the Task Panel on Prevention to the President's Commission on Mental Health is appended.

816. **Hassol, L., & Cooper, S. (1970). Mental health consultation in a preventive context. In H. Grunebaum (Eds),** ***The practice of community mental health*** **(pp. 703–733). Boston: Little, Brown & Company.**

The authors define the position of consultant as an agent of preventive intervention. The conflicts and expectations of fulfilling such a role are delineated. One such difficulty that is explored is the problem of gaining the acceptance for and maintenance of a prevention program developed by mental health consultants. The authors emphasize the need for consultation to focus efforts toward modifying environments (social, organizational) rather than solely at modifying individuals.

817. **Hinkle, Jr., L.E., & Loring, W.C. (1977).** ***The effect of the man-made environment on health and behavior.*** **Washington, DC: U.S. Government Printing Office.**

An endeavor of the Public Health Service to identify factors in the physical and social components of the residential environment of urban dwellers that relate to health and disease or to safety and injury is presented. The residential or living environment was defined as excluding occupational structures and areas devoted solely to work, but included dwellings, neighborhood, recreation areas, and service settings such as stores, schools, health care facilities, and day care centers. One objective of this undertaking was to further the understanding of alternative points for planned change or preventive intervention in aspects of the environment that should be included in guidelines for planners, architects, developers, social workers, and residents. A second objective was to provide criteria for standards and other technical advice for State and local public health agencies to consider with respect to community hygiene. The long-range goal was to effect structural and operational changes in human settlements that produce demonstrations useful in reducing disease.

818. **Insel, P.M. (1980). Task force report: The social climate of mental health.** ***Community Mental Health Journal, 16,*** **62–78.**

The contributions that social ecology can make to understanding and assessing the social environment in order to prevent mental illness are explored. Social ecology is the systematic examination of the social environment and its interaction with the physical milieu; its goal is the promotion of positive human functioning. Basic concepts of social ecology are explained. Research that examines the macroenvironmental aspects of mental illness is reviewed to suggest factors thought to influence the incidence of mental dysfunction. Use of such knowledge to design interventions and optimal environments is discussed. It is suggested that intervention in the social environment for mental illness prevention calls for an adequate concept of the environmental effects of mental health; a classification method for measuring and comparing different environments; a knowledge of the relationships between environmental variables and behavioral or psychological outcomes; and a way of determining the most effective interventions. (Author abstract modified)

819. Insel, P.M. (1980). *Environmental variables and the prevention of mental illness*. Lexington, MA: Lexington Books.

The state-of-the-art of environmental assessment, as it relates to the prevention of mental illness, is summarized. The potential health benefits of environmental interventions are outlined, and an argument for the systematic development and application of this technology within the community mental health centers (CMHC) system is presented. Significant progress in the measurement of the impact on behavior of such environmental variables as space, noise, population density, economic changes, and social supports is reported. Issues covered include: the social climate of mental health; community mental health; implications of social network research and psychosocial adaptations for community mental health practices; the impact of parental separation and divorce on youths and families; sociophysical settings and mental health; community mental health in crisis; behavioral mapping; a cognitive approach to environmental perception; and mental illness of unknown etiology.

820. Jason, L.A. (1981). Prevention and environmental modification in a behavioral community model. *Behavioral Counseling Quarterly, 1*, 91-107.

It is considered that, while mental health services can be delivered through either traditional or community paradigms, most behaviorally oriented clinicians have either implicitly or explicitly opted for the more traditional approach. The community approach represents an alternative conceptual model, one which prospectively can better meet the apparently ever-increasing demands and needs for mental health services. It is suggested that interventions embodying the most potential for salutary change (i.e., primary prevention and an emphasis on environments rather than individuals) have been too infrequently implemented. Potent obstacles to mounting such projects are described and strategies for overcoming these barriers are presented. (Author abstract modified)

821. **Jason, L.A., Felner, R.D., Moritsugu, J., & Farber, S.S. (1983). Future directions for preventive psychology. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 297–309). New York: Pergamon Press.**

In this final chapter of the book, a summary is provided, along with future directions. The authors assert that much of the progress toward the development of effective preventive efforts has been at the level of the individual or specific at-risk target populations. They suggest the need for additional attention to understanding and optimizing social structures that affect the development and well-being of the population more generally.

822. **Monahan, J., & Vaux, A. (1980). Task force report: The macroenvironment and community mental health. *Community Mental Health Journal, 16*, 14–26.**

The influence of two macroenvironmental domains, the physical and economic, on several areas of human functioning is documented. Topics in the physical domain include noise and crowding; in the economic domain, socioeconomic status, unemployment, and economic change are cited. Implications of research concerned with the macroenvironment for community mental health professionals are explored. It is recommended that whenever environmental stressors may be prevented or diminished, as in the case of noise, the mental health professional should make every effort to do so. When the macroenvironmental stressors are not preventable, as in regional economic change, the role of the community mental health professional is to mitigate their effects. (Author abstract modified)

823. **Rose, E., & Paulson, T.L. (1976). Redefining and preventing mental health emergencies in the schools. In H.J. Parad, H.L.P. Resnik, & L.G. Parad (Eds.), *Emergency and disaster management* (pp. 417–431). Bowie, MD: Charles Press.**

The authors state that mental health crises within a school setting extend beyond the "identified problem students" to the institution itself. One goal of a mental health consultant is to facilitate institutional growth through crisis by means of the recognition of and response to the communication of felt needs. This paper reports a pilot project designed to help school staff redefine singular problems as examples of categories of problems. In this manner, not only is the identified problem confronted, but the institutional conditions, which the one specific problem represents, are recognized. Three examples of perceived crisis in elementary and secondary school settings are presented. In each case, the authors' consultation was aimed at facilitating school staff's examination of their own resources for meeting the crisis conditions; not just in a way to resolve the immediate crisis, but also to meet the institutional needs expressed by the crisis.

824. **Schoggen, P. (1978). Utility of the behavioral settings approach. In D.G. Forgays (Ed.), *Primary prevention of psychopathhology, Vol. 2: Environmental influences* (pp. 164–179). Hanover, NH: University Press of New England.**

The behavior setting survey is defined as a method for studying, systematically and quantitatively, the environments that place situational coercions on people's molar behavior. The role of researchers in analyzing behavior settings is discussed. Examples of research using this methodology and results of those studies is summarized. For example, the psychological consequences on inhabitants of undermanned ecological environments are presented.

825. **Swift, C. (1980). Task force report: National Council of Community Mental Health Centers Task Force on Environmental Assessment. *Community Mental Health Journal, 16*, 7–13.**

The background and aims of the National Council of Community Mental Health Centers Task Force on Environmental Assessment are discussed as an introduction to the remaining papers in the journal, which are products of the task force's work. The charge of the task force was to show the relationship between environmental variables and behavioral outcomes for the field of prevention of mental illness; to cite directions in research in environmental assessment with application to the field of prevention of mental illness; to review and evaluate the tools and methods used to assess environments, with a focus on social environments; and to work toward the development of assessment tools relevant to the field of mental health. Four justifications are offered for funding community mental health center initiatives in environmental interventions. (Author abstract modified)

826. **Vincent, T.A., & Trickett, E.J. (1983). Preventive intervention and the human context: Ecological approaches to environmental assessment and change. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 67–86). New York: Pergamon Press.**

An ecological metaphor is proposed as a general orientation to exploring the characteristics of the social contexts in which people develop or fail to develop. The importance of understanding the effects of different contexts on human behavior in the design of preventive programs is discussed. Kelly's ecological analogy and Moos's social ecology approach are presented for their heuristic value, empirical base, and concern with the integration of understanding and action. The value of these approaches for guiding the development of preventive interventions in the social environment rests on the solid assessment methodology developed by Moos and the rich heuristic value of Kelly's work. These approaches provide a broad conceptual frame conducive to the consideration of the complexities of person-environment interaction.

827. **Wandersman, A., Andrews, A., Riddle, D., & Fawcett, C. (1983). Environmental psychology and prevention. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 104-127). New York: Pergamon Press.**

The effects of the physical environment on human behavior, stress, and coping are discussed. Potential points of preventive interventions are presented, given the underlying assumption that stress-producing environmental conditions will be associated with attempts to cope, that coping attempts may be successful or unsuccessful, and that positive or negative outcomes may result. Preventive psychologists may intervene at the environmental level to reduce or prevent mental health problems or maladaptive behaviors. Given the effect of environmental stressors on many people who never enter the mental health system but suffer from preventable stress, the reach of community and environmental psychologists can be extended if the environment is considered as a point of intervention.

See also: 21, 38, 39, 71, 72, 73, 74, 78, 85, 93, 97, 122, 183, 211, 217, 426, 551, 678, 751, 752, 850, 904, 907, 908, 910, 912, 935, 979.

B. Changing Social Systems

828. **Albee, G.W. (1980). The fourth mental health revolution. *Journal of Prevention, 1*, 67-70.**

The view is presented that the mental health field is on the threshold of the fourth mental health revolution, emphasizing social changes aimed at improving the quality of life and reducing avoidable stresses. This revolution would challenge the authority of the mental health establishment, attack the ritualistic devotion of one-to-one intervention, and expose the fallacies of the illness model. The first three mental health revolutions are briefly reviewed: Pinel's liberation of the insane from Paris dungeons, Freud's revelations about the unconscious origins of human behavior, and the creation of community mental health centers in 1964. Six characteristics and conditions of all revolutions are outlined and related to the coming social revolution in the human services field.

829. Albee, G.W. (1981). Politics, power, prevention, and social change. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 5-25). Hanover, NH: University Press of New England.

The article begins by examining the controversy concerning the medical model versus social learning approaches to understanding psychology. The author recounts criticism of primary prevention efforts made by psychologists and discusses possible reasons for these critiques. The author traces the roots of the medical model view of psychopathology to Calvinism and Puritanism. The contrasting views of seeing "mental illness" as the result of a "defect" found within the individual versus seeing it as a by-product of pernicious social influences are examined. The author believes that improvement in the mental health of large numbers of people will not come about without substantial changes in the distribution of power and changes that would lead to more economic equality throughout society. The author believes such changes should attempt to redress the economic and social inequities that affect disadvantaged members of society.

830. Cahill, J. (1983). Structural characteristics of the macroeconomy and mental health: Implications for primary prevention research. *American Journal of Community Psychology, 11*, 553-571.

Recent research on the impact of economics on mental and physical health has raised fundamental questions about structural elements in the macroeconomy. Specificially, five characteristics of our current economic system (instability in the business cycle, unemployment, inequality in income distribution, capital mobility, and fragmentation of the work process) appear to play some pathogenic role in the incidence of behavioral and physical disorders. These macroeconomic elements require intervention at the social policy level since they seem to be more powerful than the individual coping mechanisms of some demographic subgroups. Psychologists can play an important role in policy decisions by providing data on the relative impact of structural economic variables on human functioning. Examples of structural research are presented, and the implications for primary prevention are discussed. (Author abstract) ©Plenum Publishing Corp.

831. **Catalano, R., & Dooley, D. (1980). Economic change in primary prevention. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 21–40). Beverly Hills, Sage.**

A distinction is made between proactive and reactive primary prevention. The former assumes that the causal agent, or risk factor, is controllable or preventable and has as its goal preventing or avoiding the stressor. The latter is aimed at improving the coping response triggered by the stressors. It can occur before or after the stressor and is aimed at the individual who will react and cope with that factor or event. A second set of distinctions is made along a continuum of levels (from micro to macro) of stressor or adaptation demands. Preventive interventions at the micro level are focused on the individual. At the macro level, prevention is aimed at the environmental, social, or lower economic level. It is stated that the current Prevention Task Panel favors research and development on the micro level and that macro-level proactive approaches are generally rejected. It is the view of the authors that this should receive more consideration. It is believed that the contribution of ecological variables to behavioral disorder are underemphasized. Economic change, a macro-level variable, is considered as a possible cause of disorder from both proactive and reactive primary prevention perspectives. The opportunity for prevention programs of both types is discussed. In preparing populations for economic change, education, cognitive restructuring, and behavioral training are suggested techniques, and social support is important. Also, alternative management policies at the regional level are suggested.

832. **Friedan, B. (1981). Women—new patterns, problems, possibilities. In J.M. Joffe & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 240–252). Hanover, NH: University Press of New England.**

This article discusses developments in the women's movement. The author cites statistics that reveal a large decline in mental disorders affecting women over 40. Such improvement over the last 20 years in women over 40 is attributed to large changes in the role of women in society. The author goes on to discuss some of the beneficial effects that these changes have had for women as well as some of the problems that have developed. New issues that affect women, such as if and when to have children, are addressed. Also discussed is the importance of the feminist perspective in appreciating both the changing roles of women and men and the influence that the women's movement has played in the primary prevention of psychopathology.

833. **Joffe, J.M., & Albee, G.W. (1981). Powerlessness and psychopathology. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 321–325). Hanover, NH: University Press of New England.**

The authors present conclusions they reached from the papers presented at the fifth Vermont Conference on the Primary Prevention of Psychopathology. The authors conclude that the exploitation of power and the feelings of powerlessness and of hopelessness in certain individuals is a root cause of psychopathology. To prevent pathology, they argue for a redistribution of power through a redistribution of wealth in American society.

834. **Konopka, G. (1981). Social change, social action as prevention: The role of the professional. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 228–239). Hanover, NH: University Press of New England.**

This article addresses lessons that should be learned by professionals who work with individuals and who are involved in social change. Calling upon her youth in Germany, her experience in a concentration camp, and her years of public service in America, the author suggests five important lessons that professionals should learn: (1) Social change cannot be taken for granted. (2) Do not advocate social action if you do not intend to face the adverse consequences such action may entail. (3) Understand and think through your own philosophy and values. (4) Be honest with the means used in the political arena to achieve certain ends. (5) In any kind of work with individuals or with communities, "empty techniques" do not work.

835. **Kraft, I. (1964). Preventing mental ill health in early childhood. *Mental Hygiene, 48*, 413–423.**

Philosophical and practical issues in primary prevention of mental disorders are discussed. A strong call is made to work towards societal changes that would provide an environment conducive to mental health. The resistance to primary prevention approaches that would call into question broadly held assumptions and inequities inherent in American society are discussed. The relative ease of accomplishing effective prevention in areas that do not call into question societal values (as with preventing accidental death in children) is discussed as well. The growing biological understanding of mental disorders is explored, as well as possibilities of biological preventive approaches; e.g., prenatal intervention. Educational approaches to prevention are discussed, particularly parent education and controversy over its effectiveness. Checking on children's mental health at known times of natural developmental crisis is noted as a helpful way to identify children at risk and thus direct preventive efforts. Psychotherapy as primary prevention is discussed. Sociological influences on mental health, such as poverty and racial discrimination, are discussed. It is stated that prevention cannot successfully address biological and psychological variables in mental health without attending to societal influences and without attempting to deal with the many contradictions and inequities in American society that contribute to mental disorder.

836. **Levin, H.M. (1981). Economic democracy, education, and social change. In J.M. Joffe & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 165–184). Hanover, NH: University Press of New England.**

The author's position in this paper is that a movement towards economic democracy could reduce the incidence of psychopathology to some extent, given the degree to which pathology is created by the stressful conditions of existing work. Economic democracy refers to the democratic participation of workers in the decisions that affect their working lives. The author also discusses the relationship between the needs of work settings and the process of education in schools.

837. **Reiff, R. (1966). Mental health manpower and institutional change. *American Psychologist, 21*, 540–548.**

The author looks at mental health manpower needs in terms of the current emphasis on developing services for low-income populations. He suggests that changes in professional ideology and the organization of services will be necessary in order to work with lower-income people whose concerns and viewpoints vary considerably from traditional targets of mental health services. It is further suggested that in order to meet these needs and the overall mental health/mental illness needs of the country, an approach that emphasizes primary and secondary prevention is necessary. The preventive approach, emphasizing community action and focusing on strengths and coping, is seen as compatible with the philosophies of work with lower-income groups. The question is posed as to how this shift in ideology and priorities can come about. The author suggests that institutional change comes about as a result of clout, and if one does not have it then one must develop a vocal constituency in order to achieve the necessary clout and change. The author also suggests that what is needed is a new profession of experts in changing social systems for the prevention of mental illness.

838. **Ryan, W. (1971). Emotional disorder as a social problem: Implications for mental health programs. *American Journal of Orthopsychiatry, 41,* 638–645.**

In this paper the author addresses the question of how we conceptualize mental health problems and the implications of the conceptualization for program development. The author suggests that, in many cases, mental health problems are predictable outcomes of social injustices; therefore, preventive interventions should be aimed at society rather than individuals. He highlights this problem with respect to approaches to the mental health problems of the poor. The author points out that programs too often focus on status-related factors such as childrearing practices and early experiences that emphasize needing to change the individual. In contrast, it is suggested that more critical factors may be related to issues of power and money and these individuals' lack of financial and political impact. The author recommends mental health centers taking a broader view of mental health problems--looking at the disorders of the community as well as the individual. This would include working to increase clients' resources and power in the community.

839. **Smith, M.B. (1981). Themes and variations. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 326–333). Hanover, NH: University Press of New England.**

This article summarizes the main themes and points of divergence of articles presented at the fifth Vermont Conference on the primary prevention of psychopathology. A central theme of the conference was the concept of empowering people as a strategy of primary prevention. Such empowerment entails attempting to increase people's options and giving them more control over their lives. Another point of consensus was the view that psychopathology is predominant among those members of the society who are poor, oppressed, powerless, dehumanized, and stigmatized. A third area of consensus was an agreement over the effects of racism, sexism, and ageism in contributing to oppression and hence psychopathology. The article argues for a broad conception of mental health and that the task of primary prevention is the responsibility of everyone.

See also: 8, 12, 16, 21, 52, 55, 74, 86, 92, 97, 118, 119, 125, 128, 132, 135, 136, 157, 168, 188, 189, 205, 212, 214, 224, 426, 550, 554, 555, 622, 821, 822, 842, 847, 871, 874, 941, 967, 976.

C. Community Resource Building

840. Bierman, R., & Lumley, C. (1973). Toward the humanizing community. *Ontario Psychologists, 5*, 10–19.

The authors describe the Human Services Community. Its objectives are to demonstrate a model preventive social service system, develop paraprofessional career opportunities, develop underutilized volunteer segments of the community, and provide front–line professionals as resources. ©APA.

841. Brower, M. (1973). The emergence of community development corporations in urban neighborhoods. In B. Denner, & R.H. Price (Eds.), *Community mental health: Social action and reaction* (pp. 59–75). New York: Reinhart and Winston.

The social environment of the urban black ghetto is one of pervasive poverty, discrimination, prejudice, and lack of power; and with these go the self–hate and self–depreciation of occupying the lowest stratum of the social–caste system. The author states that ghetto residents need power in order to obtain services, promote their own self–esteem, and counteract white prejudice and that individuals acting alone cannot obtain such power. To attack their many problems successfully, it was proposed that multipurpose development organizations controlled by ghetto residents be developed, with some permanent sources of income under their own control. The accomplishments, activities, and difficulties of several Community Development Corporations are presented, and some lessons from these experiences are outlined.

842. Cardoza, V.G., Ackerly, W.C., & Leighton, A.H. (1975). Improving mental health through community action. *Community Mental Health Journal, 11*, 215–227.

This article reviews some of the theoretical ideas and empirical findings supporting the notion that societal processes produce stress which may lead to psychiatric disorder. Based on this, a conceptual model for improving mental health through community action is outlined. A case report is given describing one effort to apply the model in an urban mental health center. Steps are then suggested whereby the effectiveness of this approach to mental health through community action can be further developed and evaluated. ©APA.

843. **Collins, A.H. & Pancoast, D.L. (1976). *Natural helping networks: A strategy for prevention*. Washington, DC: National Association of Social Workers.**

In this book, the authors describe the phenomenon of natural helping networks and how natural helpers in neighborhoods may be identified and supported by mental health consultants. The theoretical assumption underlying the research and demonstration project was that informal, unorganized networks of indigenous helping relationships exist in small towns and rural communities; these networks cannot be duplicated and should not be supplanted by professional practice. Instead, these efforts should be nurtured and extended. The project's first phase was that of locating and interviewing natural helpers; the second involved observing and, when necessary, supporting their activities; the third included evaluating and reporting. The importance of natural networks in preventing psychological disturbance is a theme throughout the book.

844. Lewis, J.A., & Lewis, M.D. (1977). *Community counseling: A human services approach*. New York: Wiley.

A human services approach to community counseling is presented, to help community members live more effectively and to prevent the problems most frequently faced by counselors. The community counseling approach involves four main facets: (1) extensive experiential programs that provide direct educational experiences for the community as a whole; (2) intensive experiential programs that provide special experiences for individuals or groups that need them; (3) extensive environmental programs that attempt to make the entire community more responsive to the needs of all of its members; and (4) intensive environmental programs that intervene actively in the environments of specific individuals or groups to meet their special needs. Decentralized, neighborhood-based agencies that utilize the skills of local people provide greater accessibility for those in need and also greater sensitivity to problems in the environment. It is asserted that whether or not this approach will ultimately become the reality in all helping networks depends on the combined efforts of trainers, human service administrators, workers, and consumers.

845. Nangeroni, A.B. (1968). Social action in preventive psychiatry. *Canada's Mental Health, 16*, 19-24.

This article describes a preventive intervention aimed at changing a community social system through community development and enrichment. The intervention took place over a 4-year period and involved the use of 23 undergraduate volunteers who spent their summers living with local families while developing projects for children, adolescents, and adults. The volunteers lived in what was considered a disintegrated Canadian community and worked to organize various clubs and organizations in which community residents could participate. The authors claim two improvements in the community as a result of the intervention: (1) an expansion of resources and capacities within the community, and (2) an expansion and strengthening of ties with the wider community of the county and province. It is noted that the volunteers served as catalysts in the development of the community and that local residents carried on the progress that was made.

846. **Naparstek, A.J., & Haskell, C.D. (1977). Neighborhood approaches to mental health services. In L. Macht (Ed.), *Neighborhood Psychiatry* (pp. 31–42). Lexington, MA: DC Health.**

The problems of devolving power in neighborhood approaches to mental health and options for linking services to neighborhoods are outlined, including resource allocation as one of the fundamental components of the devolution of power. The principle of equity is defined as it relates to the citizens of the community; i.e., whether their neighborhood is getting its fair share of resources as compared to other parts of the city. Ethnicity and social class are especially significant influences on well-being and have strong impact on how prevention and treatment services are defined. It is concluded that the greatest challenge in a neighborhood approach to mental health is linking funds and programs to local conditions and strengths.

847. **Peck, H.B., Kaplan, S.R., & Roman, M. (1966). Prevention, treatment, and social action: A strategy of intervention in a disadvantaged urban area. *American Journal of Orthopsychiatry, 36,* 57–69.**

This article describes the initial phase of an intervention in a disadvantaged urban area in which an attempt is being made to integrate community mental health and social action approaches. The need for innovation in a seriously disadvantaged area is described, and the conceptual orientation of the project is portrayed as system oriented and focused on the relationship between the individual and the staffing of neighborhood service centers. The use of nonprofessionals is given as an example of an innovative approach designed to bring about change in the mental health status of the community. Implications for the roles of mental health professionals in preventive/social action efforts are drawn.

848. **Pilisuk, M., Parks, S.H., Kelly, J., & Turner, E. (1982). The helping network approach: Community promotion of mental health. *Journal of Primary Prevention, 3,* 116–132.**

The Galt Helping Network Project was a 2-year program to augment mental health and community services in a rural California community through the use of natural or informal resources. The experiment made use of a preventive intervention model that identified important community needs of local youth and families, board and care residents, citizens in general, and the Mexican-American community in particular. It brought a number of volunteers into the provision of direct services and created a number of institutional forms through which continued services and enlarged voluntary participation in community affairs could continue beyond the official end of the project. This article concludes that the Galt Helping Network Model can provide a major contribution to mental health maintenance and community involvement through the recognition of natural helpers and the involvement of the community in an active form of problem-solving. Through these methods a community with limited fiscal resources can take a major step toward providing a caring and helping environment for its members. (Author abstract) ©Human Sciences Press.

849. **Porter, R.A., Peters, J.A., & Heady, H.R. (1982). Using community development for prevention in Appalachia. *Social Work, 27,*** 302–307.

The author describes a university-based program designed to improve social integration in small Appalachian communities by generating affiliative and participatory behaviors as well as integrative community structures. The program is designed to develop collective coping capacities, alter lifestyles, and reduce stress in vulnerable populations such as the elderly, housewives, and adolescents. Although these social structures and processes may initially be reparative, as they stabilize over time they also have the potential for prevention. ©APA.

850. **Porter, R.A. (1983). Ecological strategies of prevention in rural community development. *Journal of Primary Prevention, 3,* 235–243.**

Preventive strategies within the framework of an ecological paradigm combine elements of theory, ideology, and practice method, among others. The theory posits a relationship between socially integrated community systems and wellness, both physical and mental. The ecological focus on adaptation constrains an ideological emphasis on health and on the natural caring function of the "informal economy." Practice strategies focus on the design of supportive environments that enhance competence and maximize the utilization of natural social processes for the achievement of preventive ends. (Author abstract) ©Human Sciences Press.

851. **Raber, M.F. (1977). An approach for cultivating personal and leadership skills in the community.** In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 90–92). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.

Goals of Leadership Inc. (LINC), an experiential learning-based primary prevention program designed by the Prairie View Mental Health Center to deal with community change and conflict, is discussed. LINC objectives included: (1) identification and understanding of community problems that influence effective individual and group functioning; (2) development of methods and programs to alleviate community-identified problems; (3) inter-agency and group coordination; (4) reduction of communication barriers; (5) development and facilitation of community leadership; and (6) mobilization of resources and development of programs and leadership skills resulting in community improvement. The LINC program ran for 5 years and was terminated when program momentum could be maintained through community leadership alone.

852. **Saunders, S. (1979). Primary prevention from a neighborhood base: A working model.** *American Journal of Orthopsychiatry, 49*, 69–80.

The author describes a neighborhood development project in which citizens were organized to work with mental health professionals in the area of primary prevention. Emphasis is placed on methods for mobilizing citizen involvement, methods used by citizens to identify high-risk populations, the working relationship between volunteers and professionals in designing and implementing services, the types of services developed, and an assessment of the project's impact. ©APA.

853. **Saur, W.G. (1977). Identifying community resources for families under stress.** *Family Coordinator, 26*, 304–306.

A method for helping high school pupils identify community resources for families under stress, suitable for inclusion in a family life and health curriculum, is outlined. Pupils are provided with a general topic outline and asked to describe and list family stress conditions or situations. Pupils are then asked to identify all possible community resources available to individuals with family problems. Following interview skill training, pupil teams are assigned interviews with various community resource personnel. Team reports and discussion of interviews are then scheduled. Finally, a booklet of community resource listings and interviews is compiled, reproduced, and distributed to class members. The study unit could be further expanded by inclusion of preventive resources and activities, as well as informal resources such as kin networks and neighbors.

854. **Trotter, S. (1982). Neighborhoods, politics and mental health. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change*. Hanover, NH: University Press of New England.**

This article advocates a strategy of prevention that involves strengthening the bonds and informal relationships of members of a neighborhood. Several projects are discussed that have involved building and improving resources within a neighborhood. A commonality to these programs is that the neighborhood problems are identified by local residents as opposed to outside experts and thus the responsibility for their solution is accepted by the residents themselves. The process of problem solution by local residents strengthens informal networks, and the resources and networks that are developed to deal with one problem are in place to tackle the next one.

See also: 45, 203, 497, 547, 550, 612, 864, 889, 893, 899, 918, 931, 932, 948, 979, 1000, 1003, 1004, 1005.

XV. Utilizing Communication Technologies as a Primary Prevention Strategy

Some primary prevention interventions have involved the dissemination of information to the general public who, in turn, might profit from obtaining such knowledge in a manner that has preventive effects. This section includes articles describing the use of various means of communication such as television, radio, the telephone, and the print medium in attempts to deliver information to the public for purposes of primary prevention.

A. Television, Radio, and Interactive Television

855. **Bernstein, S.B., & MacLennan, B.W. (1975). Community psychiatry with the communications media. In F.V. Mannino, B.W. MacLennan, & M.F. Shore (Eds.), *The practice of mental health consultation* (pp. 97-104). New York: Gardner Press.**

The role of a community psychiatrist as a mental health consultant to a commercial radio station is described. The project involved consultation in the areas of intramural staff relations and organizational needs, mental health program planning, off-the-air community-oriented activities, and subsequent collaboration with the station in a community action program. Possible roles of the media in preventive psychiatry and in the initiation of positive action to foster community mental health are also discussed.

856. **Flannery, Jr., R.B. (1980). Primary prevention and adult television viewing: Methodological extension. *Psychologist Reports, 46*, 578.**

A preventive intervention involving television viewing by adults is described. The program involved an urban television station's presentation of mental health topics on its evening news in eight videotaped segments. The segments were 2 to 4 minutes in length and showed among other things: drug abuse among adolescents, child abuse, and the effects of lupus. Volunteers agreed to watch the evening news nightly and to complete an assessment questionnaire received at the end of each week. Results indicated that the lupus and drug abuse segments resulted in increased knowledge. Total viewers and viewing hours declined by one third during the 5-week period. One conclusion reached from the study was that length of time that the segment was aired is considered central to the message's effectiveness.

857. **Keegan, C.A. (1982). Using television to reach older people with prevention messages: The over easy experiment. *Prevention in Human Services, 2*, 83-92.**

Results are presented from the 1978 multimethod national summative evaluation of the goal-directed television program, Over Easy. Targeted to persons 55 years of age and older, and setting informational, attitudinal, and behavioral objectives, the Over Easy program successfully communicated prevention information, conveyed a positive philosophy of aging, and encouraged target group utilization of existing social services. Three design features of the Over Easy intervention are recommended for future social interventions attempted through television. These include (1) integrating the program within existing networks of social services for the populations, (2) attending to informational and attitudinal forces likely to influence the effectiveness of ameliorative activities, and (3) concentrating on encouraging target group maintenance of self-help, preventive behaviors. (Author abstract modified)

858. **Lovelace, V.O. & Huston, A.C. (1983) Can television teach prosocial behavior? In J. Sprafkin, C. Swift, & R. Hess (Eds.), *Rx Television: Enhancing the Preventive Impact of TV* New York: Haworth Press.**

"Prosocial" refers to behaviors generally deemed desirable by the society and appears not only on television programs designed to be educational or therapeutic but on commercial television as well. This article discusses prosocial television and its effects on children's learning and behavior. Three strategies for presenting prosocial content are outlined: (1) presenting prosocial behavior only, which, it is concluded, is an effective way of increasing prosocial responses in viewers; (2) presenting prosocial behavior as a method of resolving conflict or in contrast to antisocial behavior, which is described as less successful in achieving intended goals; and (3) presenting conflict without resolution, also seen as relatively useful, particularly for children over 7 or 8.

859. **Mikulas, W.L. (1976). A televised self-control clinic. *Behavior Therapy, 7*, 564-566.**

The use of television as a tool for teaching self-control procedures was tested with a series of seven shows that attempted to give instruction in relaxational self-desensitization, operant analysis of behavior, token systems, thought stopping and covert sensitization. Responses to a questionnaire indicated that most of the viewers learned to observe their behavior more objectively. The show on relaxation was the most successful. Other procedures that were easily taught were those that were simple in concept and could be carried out quickly, such as altering operant cues, simple contracting, and thought stopping. More involved procedures such as self-desensitization and self-contracting were less successful. The success of this approach indicates the possibilities of its use in preventive mental health care.

860. **Ohio Department of Mental Health and Mental Retardation. (1973). Television as a tool in primary prevention. *Hospital & Community Psychiatry, 24*, 691-694.**

Commercial television as a medium for primary prevention in the field of mental health is discussed, based on an experiment begun in 1969 by the Ohio Department of Mental Health and Mental Retardation. Three series of films based on crisis theory and techniques ultimately were produced; they dealt with crises in marriage, adolescence, and childhood. Each series contained segments of a minute or less that could be shown as public service announcements during prime viewing hours. Only the childhood series received enough exposure to be considered successful. However, project officials believe it proved the efficacy of using commerical TV in a program of prevention for a wide range of crisis situations.

861. **Ratcliffe, W.D., & Wittman, W.P. (1983). Parenting education: Test market evaluation of a media campaign. *Prevention in Human Services, 2,* 97–109.**

Television advertising offers a preventive tool that can influence behavior in positive directions. This paper reports on the evaluation of a television campaign on parenting designed to foster more positive emotional environments for young children (under 5) and to teach and remind parents of basic childrearing skills. The results of a limited test-market campaign revealed positive changes in parenting beliefs in the primary target audience--mothers of young children--and self-reported changes in behavior in line with campaign objectives among 22 percent of campaign viewers. These positive results led to a modified Onatario-wide campaign with similar indications of positive impact on parenting. (Author abstract) ©The Haworth Press.

862. **Schanie, C.F., & Sundel, M. (1978). A community mental health innovation in mass media preventive education: The alternatives project. *American Journal of Community Psychology, 6,* 573–581.**

An innovative mental health primary and secondary prevention program employing mass media was conducted in the Louisville metropolitan area. For 60 weeks during public service announcement time slots, 21 educational mental health and mental retardation messages were aired on local major radio and TV stations. Three project goals were established: improved mental health attitudes, increased awareness of community mental health resources, and increased utilization of community mental health resources. Systematic evaluation, based on data from client-initiated telephone contacts and surveys of the community, indicates that the project increased awareness and utilization of community mental health resources. Positive change was indicated, overall, for attitudes related to cognitive structuring of problem situations. Attitudes related to behavioral resolution of problem situations appeared to be generally uninfluenced. Implications and future directions for the utilization of mass media in community mental health are discussed. ©APA.

863. **Solomon, D.S. (1983). Mass media campaigns for health promotion. In J. Sprafkin, C. Swift, & R. Hess (Eds.), *Rx Television: Enhancing the Preventive Impact of TV*. New York: Haworth Press.**

Citing the potential value of television as a positive influence on health-related behaviors, the author describes five programs, three successful and two unsuccessful, as examples of the use of television as a health-promoting tool. Based on an analysis of these studies, the author then discusses important considerations in planning televised health campaigns. Three considerations are stressed: (1) whether or not television is appropriate for the campaign's stated objectives; (2) using the wealth of data available on television audiences to make such strategic decisions as when a message will reach the largest number of the intended audience; and (3) the question of cost as it relates to the decision to use public service as compared to paid television advertising.

864. **Swift, C. (1983). Applications of interactive television to prevention programming. In J. Sprafkin, C. Swift, & R. Hess (Eds.), *Rx Television: Enhancing the preventive impact of TV* New York: Haworth Press.**

The development of interactive television provides expanded opportunities for prevention research and practice. Three key prevention strategies are (1) intervening with populations at risk, (2) training caregivers, and (3) building competent communities. This paper describes these applications of interactive television. Three interactive systems--Berks Community Television in Reading, Pennsylvania; QUBE in Columbus, Ohio; and Hi-Ovis in Japan-- are discussed in the context of their contributions to the promotion of competent communities. It is concluded that, while interactive television provides a medium for a variety of prevention programs, both in the form of educational interventions and as a method for showcasing citizen concerns about particular community issues, data on its effectiveness is currently scanty. (Author abstract modified)

865. **Wolkon, G.H., & Moriwaki, S. (1973). The Ombudsman Programme: Primary prevention of psychological disorders. *International Journal of Social Psychiatry, 19,*** 220-255.

The authors discuss ombudsman programs recently sponsored by mass media to help individuals cope with public and private bureaucracy. Since the stress of coping with a complex and bureaucratic society is the cause of much mental illness, successful ombudsman programs may be viewed as preventers of mental illness. The relation of reality stress to mental illness is considered. The ombudsman program of radio station KABC, Los Angeles, is described in detail. ©APA.

866. **Wolkon, G.H. & Moriwaki, S. (1977). The ombudsman: A serendipitous mental health intervention. *Community Mental Health Journal, 13*, 229–238.**

It is proposed that the ombudsman program, originally conceived of as a protection of the political rights of individual citizens, can be profitably viewed as a primary prevention of psychological disorders. The ombudsman attempts to alleviate reality problems prior to the onset of psychological disruption by engaging in active change agentry in public and private bureaucracies. Analysis of the ombudsman role at a California radio station showed that a significant proportion of the complaints received concerned issues that often affect the individual psychologically, although the complaints were lodged as administrative/legislative ones. Mental health professionals are encouraged to support the ombudsman program, serve in an advisory capacity in terms of their knowledge of community mental health resources, and train ombudsmen so that they will use psychological understanding and insight in dealing with persons seeking their help.

See also: 501, 556, 629, 667, 889.

B. Others

867. **Diseker, R.A., Michielutte, R., & Morrison, V. (1980). Use and reported effectiveness of tel-med: A telephone health information system. *American Journal of Public Health, 70*, 229–234.**

In January 1977, a Telephone Information System (Tel-Med) was begun in Winston-Salem, North Carolina. A survey was conducted to determine how Tel-Med was meeting the community's need for health information and to see if program objectives were being met. Respondents in 3,005 randomly selected households were interviewed by telephone to determine user characteristics, user motivation, action taken, knowledge and information gained, and system improvements. A key finding indicated that larger percentages of adults with lower incomes and educational levels were not aware of the service than were the adults with higher income and educational levels. However, income and education are not related to use of Tel-Med among individuals who know of this service. This finding suggests that the poorer and lesser educated would use Tel-Med in a way similar to that of their more fortunate peers if efforts were made to inform them of the service. (Author abstract)

868. **Morgan, S.R. (1976). Bibliotherapy: A broader concept.** ***Journal of Clinical Child Psychology, 5,*** **39–42.**

A concept of bibliotherapy is presented that encompasses its preventive potential as well as its therapeutic value. Emphasis is on the interactive process and its relationship to factors that could compound or provoke academic failure or emotional disturbance in school children. Book selections are discussed in terms of fear induction, effect on children's self-esteem and motivation, and therapeutic intent of books written about specific problems. The importance of followup discussions under the leadership of a teacher is emphasized.

869. **Rothenberg, M.B. (1979). Public information and education. In I.N. Berlin, & L.A. Stone (Eds.),** ***Basic handbook of child psychiatry, Vol. 4: Prevention and current issues*** **(pp. 178–185). New York: Basic Books.**

The thesis of this article is that properly conceptualized, developed, and delivered public information and education can play a major role in the primary prevention of a variety of psychological, behavioral, and social disorders. Discussion begins with the question of whether or not information disseminated from experts to lay persons can modify lifestyles to improve health. Factors in effective education and information delivery to individuals is given, including what can be learned from social learning theory. The problem of whether behavior is changed in individuals even when knowledge and attitudes have been appropriately influenced is addressed. Two examples of public health information and education programs are discussed. One is the efforts of the National Foundation for Sudden Infant Death and the other is the Stanford Heart Disease Prevention Program. With the latter, it was shown that a combination of public information delivery through the mass media in combination with direct one-to-one and group intervention was effective in reducing the incidence of smoking in the community and more effective than just using the media alone. The author concludes by stating that a combination of communication theory, social learning theory, a psychodynamic understanding of unconscious processes, and an understanding of child and adolescent development can provide mental health professionals with the theoretical framework with which to develop public information and education programs designed for purposes of primary prevention.

870. **White, D.M. (1981). "Mediacracy": Mass media and psychopathology. In J.M. Joffe, & G.W. Albee (Eds.), *Primary prevention of psychopathology, Vol. 5: Prevention through political action and social change* (pp. 153–164). Hanover, NH: University Press of New England.**

The author believes that certain aspects of the mass media, particularly television, contribute to psychopathology. Data on the number of hours citizens spend involved with some form of mass media are discussed as well as the negative aspects of such involvement. The author advocates the formation of citizen groups to protest some of the practices of television networks and to lobby for laws that would more strictly regulate the networks.

XVI. Mental Health Promotion

Primary prevention of psychopathology is usually conceptualized as the prevention of certain negative end states within individuals. In contrast to this is the idea of promoting the mental health and emotional well-being of healthy individuals in a further, more positive, direction. Articles in this section explore or argue the merits of this approach. One article describes a mental health promotion program.

871. **Ahmed, P.I., Kolker, A., & Coelhc, G.V. (1979). Toward a new definition of health: An overview. In P. Ahmed (Ed.), *Toward a new definition of health* (pp. 7–22). New York: Plenum.**

The background and limitations of the preponderantly medical definition of health are reviewed, and the rationale for expanding the definition to include nonmedical dimensions is discussed. It is contended that the medical profession has traditionally defined health as merely the absence of disease and disease as an observable deviation from a biostatistical norm derived within a given historical experience and language system. Attention is directed to individual and cultural variations in the concepts of sickness and wellness and the importance of viewing the concepts as complex behavioral entities consisting of psychological and sociocultural dimensions as well as biological ones. Such an approach provides guidelines for preventive action, and several socioenvironmental and behavioral forces that contribute to disease are identified. Preventive efforts should concentrate on social, educational, and economic policies that affect these forces and on personal lifestyle changes.

872. **Baruch, G.K. & Barnett, R.C. (1980). On the well-being of adult women. In L.A. Bond & J.C. Rosen (Eds.), *Primary prevention of psychopathology, Vol. 4: Competence and coping during adulthood* (pp. 240–257). Hanover, NH: University Press of New England.**

The authors' major theme in this paper is that in this society the psychological well-being of women is facilitated: (1) by the development of occupational competence and of the capacity for economic independence, and (2) by involvement in a variety of roles. The authors first discuss the social changes that have made occupational competence and economic independence important for women's successful adaptation. They then review evidence about the effects of multiple role involvement on psychological well-being in a group of married women with young children who differ in employment status. Findings indicated that the well-being of nonemployed women is highly dependent upon their husbands' approval of their role. For employed women, the husband's approval mattered, but to a lesser degree; in addition, their own commitment to work and their satisfaction with their current jobs contributed heavily to indices of well-being. Involvement in multiple roles does not necessarily lead to debilitating levels of strain and may be a protective factor later in the life cycle when children leave the home. The authors state that their work supports the value of preparing girls from childhood on to develop and exercise occupational competence.

873. **Gross, S.J. (1980). The holistic health movement. *Personnel and Guidance Journal, 59*, 96–100.**

Holistic health programs are placed within a conceptual framework to enable counselors to consider its implications in addressing a new service area. The framework is also offered as a model for self-development. Holistic health refers generally to all the practices and philosophies that consider total individuals in their approaches to well-being. Holistic health and traditional approaches to healing are contrasted. Holistic health is described as having unique emphases on positive wellness, environmental concerns, self-responsibility, and such practices as meditation, fitness, nourishment, vitality, and spirituality, each of which is discussed. Implications of holistic health for counselors are drawn. (Author abstract modified)

874. **Guttmacher, S. (1979). Whole in body, mind and spirit: Wholistic health and the limits of medicine. *Journal of American College Health Association, 28*, 180–185.**

The influence of the holistic health movement on the quality of future health care is discussed. This movement could lead to a deeper recognition of the relationship between the health of the individual and the way in which society is organized, and could stimulate popular action challenging those conditions that generate stress or living conditions that lead to physical and mental illness and disability. Because the movement operates within the same political and economic constraints as the biomedical model, however, it is open to many of its criticisms, including an overemphasis on individual development and on the spiritual dimensions of cure, the paradox of self-help, and social class bias.

875. **Hettler, W. (1980). Wellness promotion on a university campus. *Family and Community Health, 3*, 77-95.**

A comprehensive health promotion/lifestyle improvement program, started 8 years ago at the Stevens Point campus of the University of Wisconsin, is described. The program is based on the premise that each individual develops a unique lifestyle that reflects and changes with the individual's intellectual, emotional, physical, social, occupational, and spiritual dimensions, and that wellness consists of a positive approach that emphasizes the whole person. The Student Life Division, involving the health services, counseling services, residence hall program, and university centers, has been actively promoting wellness through provision of student services, student development, and outreach. An important part of the total program is the Lifestyle Assessment Questionnaire, which includes inventories for evaluating wellness, risk of death, personal growth, and medical alert.

876. **Public Health Service (1979). *Healthy people: The Surgeon General's report on health promotion and disease prevention*. (DHEW Pub. No. (PHS) 79-55071). Washington, DC: U.S. Government Printing Office.**

National health priorities and measurable goals are identified in order to enhance both individual and national perspectives on health promotion and disease prevention. Risks to good health (major risk categories, risk variability, age-related risks) are discussed. The goals for healthy infants and children are seen as: (1) reducing the number of low birthweight infants, (2) reducing the number of birth defects, (3) enhancing childhood growth and development, and (4) reducing childhood accidents and injuries. The goals for healthy adolescents are: reducing fatal motor vehicle accidents and reducing alcohol and drug misuse. The goals for healthy adults and older adults are: (1) reducing heart attacks and strokes, (2) reducing death from cancer, (3) increasing the number of older adults who can function independently, and (4) reducing premature death from influenza and pneumonia. Other topics discussed include: preventive health services (family planning, pregnancy and infant care, immunizations, sexually transmissible disease services, high blood pressure control); health protection (toxic agent control, occupational safety supplies, infectious agent control); and health promotion (smoking cessation, reducing misuse of alcohol and drugs, improved nutrition, exercise and fitness, and stress control).

See also: 44, 48, 49, 52, 58, 119, 122, 182, 183, 184, 192, 197, 272, 310, 602, 604, 606, 629, 634, 635, 642, 651, 656, 722, 814, 863, 877, 913, 936, 952.

XVII. Settings for the Implementation of Primary Prevention Programs

Various institutions, such as schools and community mental health centers, have provided the setting for a number of different primary preventive interventions. Articles in this section were those best categorized by the nature of the setting in which the preventive intervention took place and those that discussed the role such settings should play in primary prevention. This section has articles involving the following settings: (1) CMHCs, (2) schools, and (3) other various settings.

A. Community Mental Health Centers

This category is divided into two parts. The first includes articles that either describe surveys of the preventive activities of community mental health centers, discuss the role such centers should play in implementing preventive programs, or discuss issues involved with primary prevention in this type of setting. In the second section are articles that describe primary prevention programs developed and run by staff members of various community mental health centers.

1. Surveys of Activities and Position Papers

877. **Adler, P.T. (1982). Mental Health promotion and the CMHC: Opportunities and obstacles. In F.D. Perlmutter (Ed.), *New directions for mental health services: Mental health promotion and primary prevention* (pp. 45-56). San Francisco: Jossey-Bass.**

The opportunities for and obstacles to preventive activity by Community Mental Health Centers (CMHCs) are considered. CMHCs can promote mental health and prevent disability by competence building and social support development. At the individual level, the primary strategies of competence development are those of mental health education. Programs commonly offer the opportunity to learn and practice skills under supervised and supportive conditions.

878. **Banchevska, R. (1976). The role of the community mental health center in prevention. *Mental Health and Society, 3*, 329–335.**

The author discusses community psychiatry and the role of the community mental health center, with attention to the primary prevention program, limitations of the field of influence, and the scope of activity within any given community. ©APA.

879. **Becker, R.E. (1972). The organization and management of community mental health services. *Community Mental Health Journal, 8*, 292–302.**

This article uses the public health model of primary, secondary, and tertiary prevention as a basis for planning and developing mental health services in two settings. The resulting organizations proved effective in providing qualitative mental health services and in developing effective work groups throughout the organization to take responsibility for programs. Experience with this model supports specialization of State hospitals into rehabilitation facilities and their close integration with programs in the communities they serve. ©APA.

880. **Berlin, I.N. (1975). Some models for reversing the myth of child treatment in community mental health centers. *Journal of the American Academy of Child Psychiatry, 14*, 76–94.**

The author notes that community mental health services tend to focus on the most disturbed members of their catchment areas--the adult mentally ill. In a few mental health centers, a commitment to children has resulted in early intervention and prevention services. Both treatment and intervention must be initiated very early. Poverty, malnutrition, and maternal depression account for many mental illnesses in the first few years of life. Collaboration between education, health, and mental health agencies is seen as crucial for the future of mental health of children. ©APA.

881. Bloom, B.L. (1977). *Community mental health: A general introduction*. Monterey, CA: Brooks/Cole.

An overview of the field of community mental health is presented. The field is placed in its historical context and the role of the Federal Government in the provision of mental health services is highlighted. The social purposes of the Community Mental Health Act are examined. Techniques and practices specifically associated with the field of community mental health such as prevention, assessment, consultation and crisis intervention are analyzed. Critical views of the community mental health movement are reviewed, and future areas of development are suggested.

882. Cooper, S. (1980). Implementing prevention programs: A community mental health center director's point of view. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 253-261). Beverly Hills: Sage.

The author describes the "what is" of primary prevention in community mental health centers, highlighting several important issues. First, most prevention programs represent secondary and tertiary prevention efforts, not primary. Most programs lack specificity of target population and goal. Second, clinical administrators who develop programs must balance prevention needs with client demands for service. The latter are more pressing and visible while the former promise long-term gains. Collaboration of prevention projects with the community and several agencies is both important for program success and difficult, requiring considerable investments of time and energy. Efforts at collaboration must include consideration of the politics of prevention at the local level to improve chances of successful implementation of programs. Fiscal support for primary prevention is a major impediment for programming, since CMHCs depend on fees and third-party reimbursements as their major income source. Lastly, prevention programs are typically housed in the consultation and education units of the center. These units tend to be staffed by the least-senior personnel and are the least funded. This setup reflects organizational messages about the perceived value of primary prevention and should not be ignored.

883. Denner, B. (1974). The insanity of community mental health: The myth of the machine. *International Journal of Mental Health, 3*, 104-126.

The article discusses flaws in the community mental health movement; e.g., lack of clear understanding by the public of concepts applied in the movement, lack of evaluation procedures, lack of full-time prevention programs, and poor organization of centers and subdivision of function. An ideal community program is outlined. ©APA.

884. **Glasscote, R.M., Kohn, E., Beigel, A., Raber, M.F., Roeske, N., Cox, B.A., Raybin, J.B., & Bloom, B.L. (1980).** ***Preventing mental illness: Efforts and attitudes.*** **Washington, DC: Joint Information Service.**

Data from a survey of the prevention activities taking place in community mental health centers developed through the Federal support program for such facilities are presented and discussed. The survey was designed to determine what the centers were doing in terms of mental illness prevention efforts. The discussion covers issues that emerged during field visits; ambiguities and assumptions; certain attitudes encountered among those who plan programs and budgets; the knowledge, or ignorance, of the state-of-the-art in prevention; and the complexities involved in the provision of prevention services. Six programs are examined in detail.

885. **Klein, D.C. (1961). The prevention of mental illness.** ***Mental Hygiene, 45,*** **101–109.**

The author makes the distinction between a treatment-oriented mental hygiene clinic and a preventively oriented mental health center. The activities of the former mostly involve direct treatment of individual clients. The activities of the latter are broader and include consultative work with schools, mental health education, and preventive group counseling. Its major responsibility is to a population of people who make direct use of clinical and educational services as well as to those who do not use the services directly. The author states that, at the present time, it would seem wisest to concentrate preventive efforts on the control of harmful reactions to highly stressful conditions.

886. **Klein, D.C., & Goldston, S.E. (1977). Summary report of preconference survey on primary prevention programming. In D.C. Klein, & S.E. Goldston (Eds.),** ***Primary prevention: An idea whose time has come*** **(pp. 13–20). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

To determine types of groups/institutions involved in primary prevention programs, administrative and staffing patterns, and factors affecting commitment to primary prevention, responses of 34 (of 81 possible) directors of community mental health programs to a mail questionnaire were assessed. Data indicate that: (1) programs surveyed serve catchment areas of 84,000 to 230,000 people, in urban, mixed, and rural areas; (2) the majority of programs are centrally governed single agencies, with 82 percent operating decentralized outreach facilities; and (3) median staff time devoted to primary prevention is 5 percent and to secondary prevention is 10 percent. Major factors increasing commitment to prevention programs include: number of at-risk groups needing programs, availability of staff, importance of primary prevention as a mental health function, and Federal guidelines. Factors decreasing commitment include availability of funding, amount of effort required, evaluation ability, and State policy guidelines. Most programs worked in coordination with schools and/or social agencies. Major target groups are preschool and elementary children and adolescents. Major needs also are listed.

887. Schwartz, S. (1982). Putting primary prevention to work: Administrative dilemmas. *Administration in Mental Health, 9*, 272-280.

The author suggests that the advent of primary prevention as an integral part of community mental health practice will make new demands on agency administrators whose prior training and experience may be limited to traditional clinical settings. The author describes ways to promote programming success that involve improving the ability of administrators to recognize how the nonrational nature of prevention technology will complicate the processes of defining goals and activities, hiring and supervising staff, building interorganizational coalitions, and securing sufficient funds. ©APA.

888. Sussex, J.N. (1979). The role of the community in primary, secondary, and tertiary prevention. In I.N. Berlin & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 312-324).New York: Basic Books.

The author first discusses the domain of community psychiatry. Problems in service delivery within communities are mentioned, including the underserving of children in community mental health centers. Some of the recommendations of the Joint Commission on the Mental Health of Children are listed. The author then briefly discusses some issues in preventive and treatment services for children in community mental health centers. The role a child psychiatrist can play in the collaborative functioning of a mental health team involved in treatment and prevention efforts is discussed. Finally, issues in collaboration among agencies are mentioned.

889. **Swift, C.F. (1982). Prevention in community mental health. In D.R. Ritter (Ed.), *Consultation, education and prevention in community mental health* (pp. 170–199). Springfield, IL: Charles C. Thomas.**

In this book chapter, the author first defines the different levels of preventive intervention, giving special focus to the differences between primary and secondary prevention. Health promotion, health protection, and disease prevention efforts are delineated. The author then discusses in detail prevention activities in community mental health. The mandate given to prevention by President Kennedy in 1963 as a part of the Community Mental Health Systems Act is described. Prevention activities in CMHCs occur under the auspices of Consultation and Education (C&E). However, in most CMHCs the majority of effort and money is spent for treatment rather than for prevention through C&E. C&E preventive activities in various CMHCs are described, including an example of a community resource development project in Ann Arbor, Michigan. In conclusion, the author discusses four ongoing trends related to prevention in community mental health that have occurred primarily due to funding changes at the Federal level. These four trends include: (1) a transfer of control of prevention programs from the Federal Government to the States; (2) a reduction of C&E programs and therefore prevention in community mental health centers; (3) a growing commitment to prevention programs in health and human service agencies outside of community mental health centers; and (4) an increased reconciliation between physical and mental health fields in the implementation of prevention programs. The advantages and disadvantages of these changes are discussed as is the future of prevention activities within community mental health centers.

890. **Vayda, A.M. & Perlmutter, F.D. (1977). Primary prevention in community mental health centers: A survey of current activity. *Community Mental Health Journal, 13,*** 343–351.

Using a framework that distinguishes between institutional level interventions (caretaker training and program consultation) and individual level interventions (dealing with developmental or situational crises), data are presented from 42 community mental health centers on specific target populations that are tapped by primary prevention activities and on the content of the activities. Illustrative activities are described, and explanations of current trends are posited. Two factors important for promoting the cause of primary prevention are extrapolated from the data. First, it is recommended that a priority should be given to exposing primary prevention practitioners to appropriate and varied methodologies and strategies. Second, it is suggested that the role of the community mental health center with respect to primary prevention needs, particularly consultation and education, needs to be stipulated. (Author abstract modified)

891. **Walsh, J.A. (1982). Prevention in mental health: Organizational and ideological perspectives. *Social Work, 27*, 298–301.**

This study of 33 community mental health centers in metropolitan Chicago found that involvement in prevention was more related to the discipline of the professional than to the agency in which he or she worked. The author discovered that organizational support and ideological support of mental health professionals were critical variables for prevention programs. (Author abstract)

See also: 3, 11, 89, 94, 121, 167, 168, 176, 180, 184, 185, 233, 621, 819, 825, 838, 992.

2. Descriptions of Various CMHC-Sponsored Prevention Programs

892. **Borus, J.F., & Anastasi, M.A. (1979). Mental health prevention groups in primary-care settings. *International Journal of Mental Health, 8*, 58–73.**

Mental health primary prevention programs of a comprehensive community mental health center are described, and the advantages of the primary care setting for primary prevention interventions are discussed. The specific model of mental health preventive intervention that is described features the development of a group program, organized around an activity, to reach a target population whose members are under similar life stresses and at risk for developing disabling emotional disorders. The lack of significant monetary support from NIMH to back up its verbal encouragement of primary prevention programs is noted.

893. **Dyck, G., & Yoder, V.E. (1971). A primary and secondary prevention program. *National Association of Private Psychiatric Hospitals Journal, 3*, 24–26.**

The efforts of a private, nonprofit mental health center, Prairie View, to provide primary and secondary prevention for its surrounding community are described. The center began as a tertiary care unit, relatively removed from its community, and evolved into a comprehensive program, responsive to the needs of its surrounding community. Some of the clinic's more recent approaches to prevention are described, and suggestions are made for additional approaches. Concentrating mental health efforts on improving existing community resources is one preventive approach suggested. The use of groups made up of leaders from various segments of the community to identify problems and act as catalysts for problem resolution is described. The utilization and enhancement of "natural caregivers" (e.g. ministers, physicians) already existing in communities is discussed. It is noted that the clinic has chosen to provide services on a contract basis to communities, in order to avoid dependence on tax dollars and the regulations that come with them.

894. **Gurevitz, H., & Heath, D. (1969). Prevention and professional response. In H.R. Lamb, D. Heath, & J. Downing (Eds.), *Handbook of community mental health practice* (pp. 430–446). New York: Jossey-Bass.**

This paper describes the development of a regionalized mental health center in San Mateo County, California, which put into practice several aspects of preventive psychiatry. Included among these preventive aspects were collaboration across disciplines, consultation, mental health education, and community organization. The primary focus is on how staff responded to changes placed on them in these new roles. The authors describe how staff were not prepared, without further training to engage in prevention-oriented programs, though they responded eagerly and well to inservice training opportunities. This led to a discussion of recruitment, including the difficulty of specifying what qualities of staff would best prepare them for new roles. The importance of administrative structuring for the functioning of line staff was stressed, including the provision of support, supervision, and consultation. It was found that such areas as crisis intervention, which staff often assumed they had been trained to do, were approached as "shortened therapy" and required additional training. Lack of knowledge of indirect service delivery was cited, and a seminar was created to teach staff this aspect of preventive work.

895. **Humes-Noyes, B. (1980). Community mental health prevention and health promotion programs in rural communities. *Journal of Rural Community Psychology, 1*, 34–46.**

The author presents educational programs developed by an outreach community mental health service. The program's goal is described as the prevention of emotional disability and the enhancement of personal and interpersonal functioning of residents in rural communities. School systems were selected as an effective entry point for initiating the educational programs. Participants in the program were found to have acquired knowledge, skills, and attitudes that contributed to their mental health and the mental health of others. ©APA.

896. **Klein, D.C. (1969). The mental health center as a community laboratory. *Community Mental Health Journal, 5,* 358–366.**

The author reviews, in summary form, the work done at Wellesley Human Relations Service during its first 15 years of existence. He highlights the dual goals of research and service as a practical model for community mental health centers. Clinical studies of such issues as family coping with emotional hazards were conducted by the staff. The role of community caretakers (e.g., clergymen, public health nurses, educators) in providing preventive care during critical life points was also investigated. Surveys of community needs and services, studies of emotional hazards, and the social geography of mental health were among other research efforts conducted by the staff. The services that were coupled with this research included brief preventively oriented crisis intervention, mental health consultation, preventive group counseling at crisis points, and a preschool checkup service. The author points out that the experience of this center demonstrates that research and service interests can effectively be linked in a preventively oriented mental health center.

897. **Nahemow, I., & Mann, G. (1982). Primary prevention interventions with families that have young children: Theory and practice. *Journal of Children in Contemporary Society, 14,* 13–19.**

The authors describe the theory and practice of preventive mental health programming in a community mental health center in Pennsylvania. The center uses the Albee formula for incidence of maladaptive behavior as a theoretical base. Programming focuses on problem-solving skills, self-esteem, and support. A description of five types of preventive mental health programs--mother/infant, parent and junior toddler, parent and senior toddler, parents and three-year-olds, and parents and preschoolers--follows the discussion of primary prevention theory. ©APA.

898. **Paster, V.S. (1977). Organizing primary prevention programs with disadvantaged community groups. In D.C. Klein, & S.E. Goldston (Eds.). *Primary prevention: An idea whose time has come* (pp. 85–89). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

A primary prevention-oriented social advocacy/stressor amelioration program sponsored by a Northwest Manhattan community mental health center (CMHC) is outlined. Population served is 50 percent black, 30 percent white, and 20 percent Hispanic. Leadership training, provision of information, and development of personal competence through experience with self and community advocacy provided the means for emotional stressor amelioration. Police and the law, housing problems, and consumer concerns are a few of the areas in which training and/or advocacy were undertaken. Problems and considerations in the development, implementation, and maintenance of such a program are discussed. Positive preventive effects of the program included increased knowledge and utilization of CMHC services and greater coping abilities and self-esteem, as well as less apathy, isolation, and powerlessness among actively involved participants.

899. **Robitaille-Martin, M. (1975). An answer to district psychiatric care in an urban environment. *Canada's Mental Health*, *23*, 3–4.**

The author describes the Montreal Community Mental Health Center, developed as an alternative to traditional psychiatric treatment approaches in an urban environment. Interdisciplinary teams of professionals divide their time between preventive work and treatment. Prevention includes community action, sex education courses, research on rooming and boarding facilities, consultation with other community organizations, and other innovative techniques. Questions are raised about the possiblity of improving mental health in the community and about power in the community and the professional's relationship to it. It is concluded that a process of self-criticism is necessary if a therapeutic team is to have any influence on mental health in the community. ©APA.

See also: 380, 498, 538, 540, 604, 626, 644, 657, 851.

B. Schools

Issues involved in primary prevention in schools, or the role schools should play in such activities, form the basis of articles included in this section. This section, however, does not primarily focus on descriptions of prevention programs that took place in a school setting. Descriptions of many such programs can be found by referring to articles listed in this section's cross-references.

900. **Allen, G.J., Chinsky, J.M., Larcen, S.W., Lockman, J.E., Selinger, H.V. (1976). *Community psychology and the schools: A behaviorally oriented multilevel preventive approach*. New York: Wiley.**

A model for psychological interventions in school settings is presented. The school is viewed as a convenient setting for prevention of mental health problems. Suggestions to consultants on developing and maintaining the cooperation of the school staff are offered. A preventive approach to student maladjustment is outlined. A combination of endeavors to create the most adaptive match between people and their environment, early intervention for isolated children at high risk of maladjustment, and training of teachers in behavioral techniques of classroom management is recommended. The implementation and evaluation of this intervention model in a school system is described.

901. **Biber, B. (1961). Integration of mental health principles in the school setting.** In G. Caplan (Ed.), ***Prevention of mental disorders in children*** (pp. 323–352). New York: Basic Books.

A need for the infusion of mental health principles into all school processes and relationships is discussed. It is assumed that schooling will contribute to ego strength to the extent that learning can be made viable; i.e., that learning power can be enhanced by basing curriculum content and method on knowledge of capacity, interests, drives, and motivations of children at successive stages of development. It is also assumed that the teacher–child relationship can contribute toward the maturing of positive feelings toward self and others, deepen the potential for interpersonal relatedness, and increase the flexibility of the adaptive process. Suggestions are made for the ways educational programs can influence these goals, and studies examining the impact of school variables on personality development are discussed.

902. **Bower, E.M. (1961) Primary prevention in a school setting.** In G. Caplan (Eds.), ***Prevention of mental disorders in children*** (pp. 353–377). New York: Basic Books.

Defining primary prevention as "actions, deliberate or otherwise, that maximize those social forces in the community which tend to encourage the full development of the human being as a rational, creative, and self-actualizing organism," the author presents a case for the employment of schools in a primary prevention role. The school is often the first social institution to note inadequate development and is strategically located to deal with the child and parents. The author discusses an experimental program in a public school system. Consultation with teachers by mental health specialists encouraged better use of psychological and curriculum services by the teachers and seemed to hold promise for primary prevention. Parent group counseling helped to increase understanding and awareness of parents about their relationships with their children, and where these relationships were poor it had great preventive potential. Child care contact by girls in high school home economics classes was found to be helpful for many students unable to relate well to their classmates, and provided a real source of experiential learning about human behavior. Such school programs can apparently add measurable increments of ego strength to large groups of school children.

903. **Bower, E.M. (1979). School age issues of prevention. In I.N. Berlin, & L.A. Stone (Eds.), *Basic handbook of child psychiatry, Vol. 4: Prevention and current issues* (pp. 139-149). New York: Basic Books.**

This paper begins with a discussion of three key integrative social systems (KISS) that children encounter in the process of growing up: (1) the family, (2) peer play groups, and (3) the schools. The preventive challenge lies in integrating these social systems and the health system that supports them. Prevention in terms of schooling requires recognition of and provision for those children whose familial experiences have been inadequate to equip them with the skills and competencies required in a school setting. The respective roles of the family, peer play groups, and the school as related to sequential developmental arenas are highlighted, and the school as a prevention agency is described in terms of its potential to respond flexibly to children with a wide variety of needs. Special topics relevant to prevention, such as drug and alcohol abuse, and special problems faced by families with children who have psychological problems, are discussed.

904. **Clarizio, H.F. (1979). Primary prevention of behavioral disorders in the schools. *School Psychology Review, 8,* 434-445.**

Mental health specialists have become increasingly interested in the prevention of behavior disorders. No single institution is adequate to the task of primary prevention, but certain characteristics of the school give it advantages over other agencies. Preventive efforts to date have clustered around two main strategies--the modification of school environments and competence building--and these are discussed. Though there are many obstacles to primary prevention efforts (and these are noted), it is apparent that this diffuse concept is being translated into concrete programs. Implications for school psychologists are presented. ©APA.

905. **Cowen, E.L. (1982) Primary prevention: Children and the schools. *Journal of Children in Contemporary Society, 14,* 57-68.**

The author presents a working concept of primary prevention and emphasizes the need for such programming. Children are viewed as logical prime targets for primary prevention program efforts, and schools are considered to be natural sites for such programming. Examples are given of ongoing work in (a) early detection and intervention, (b) programs based on the helper-therapy principle, (c) mental health education, (d) competence training, (e) social-system analysis and modification, and (f) stress reduction and coping with stress. Each area is thought to hold special potential for future primary prevention work with young children in schools. ®APA.

906. **Davis, A.K., Weener, J.M. & Shute, R.E. (1977). Positive peer influence: School-based Prevention. *Health Education*, *8*, 20–22.**

This article stresses the importance of the peer group, particularly in school-age children, as a strong influence and potential resource in designing preventive interventions. Several examples of the preventive use of the peer group and peer pressure are presented. Examples include peer and cross-age tutoring, peer counseling, integrating peer pressure/peer influence into the curriculum as a resource for personal learning on the part of students, and alternative peer-related activities, such as the creation of drop-in centers and youth service programs. Resource books that outline other peer-relevant projects and approaches are mentioned, and the possible extension of the general approach into a wide variety of preventive areas is outlined.

907. **Jason, L.A. (1980). Prevention in the schools: Behavioral approaches. In R.H. Price, R. F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 109–134). Beverly Hills: Sage.**

A coherent, conceptual system for behavioral mental health preventive interventions in schools is presented, and concrete examples of this approach are given. Models of mental health service delivery, both the traditional community mental health approach and the community psychology approach, are explicitly defined. Specific, person-centered, primary preventive approaches and a range of compatible behavioral technologies are delineated. The relatively unexplored potential of preventive environmental interventions is examined. Critical issues germane to primary prevention in schools, including the feasibility of utilizing support systems and larger scale interventions, receptivity for preventive services among school personnel, prospective barriers in obtaining requisite funds for these projects, and cost effectiveness of preventive interventions are discussed.

908. **Jason, L.A. (1982). Community-based approaches in preventing adolescent problems.** ***School Psychology Review, 11,*** **417–424.**

The author discusses the theory and application of a community-based approach to delivering mental health services to school systems. Rather than focusing on youngsters with incipient or manifest psychological disorders, this approach switches the emphasis to primary preventive interventions and examines environmental and social system influences on children's development and adjustment. Possible benefits accruing from adopting a preventive model within school systems are discussed in terms of (1) ensuring that children from high-risk populations do not succumb to psychological disorders, (2) preventing the onset of specific maladaptive behaviors such as drug use, (3) building social and personal competencies, and (4) helping adolescents cope with developmental transitions. Specific areas for intervention include social support networks, the physical design of schools, and social climate. ©APA.

909. **Lamothe, P. (1975). Psychological services in the secondary school: A look ahead.** ***Canada's Mental Health, 23,*** **4–5.**

The author proposes an interventionist model of psychological services at the secondary school level. This model is aimed at the school as a whole and at the social conditions that accompany the learning process, with the psychologist as an agent of change. ©APA.

910. **Lemle, R. (1976). Primary prevention of psychological disorders in elementary and intermediate schools.** ***Journal of Clinical Child Psychology, 5,*** **26–32.**

This paper reviews primary prevention programs in elementary and intermediate schools and proposes a revised operational definition for the concept of primary prevention. For several decades, primary prevention has been advocated as a strategy for reducing the incidence of psychological disorders in the population. One setting in which primary prevention programs have frequently been developed is the school system. These programs have taken three forms: specific curriculum additions, environmental modifications, and teacher training. There has been some evidence that demonstrates positive effects of curriculum additions, although long-term followups have not been conducted to assess whether or not prevention of disorders has actually occurred. Evaluation of modified environments and of teacher training is difficult because too few studies have measured program effects on school children. Descriptions of programs have suffered from the following important omissions: (1) explicit operationalization of program variables and

(2) calibration of program content to age-appropriate readiness. A mutually acceptable definition of primary prevention has eluded writers in the field of mental health. A simplified schema for conceptualizing primary prevention that synthesizes previously proposed definitions is advanced. (Author abstract modified)

911. **Medway, F.J. (1975). A social psychological approach to internally based change in the schools.** ***Journal of School Psychology, 13,*** **19–27.**

An analysis of current models of delivering preventive psychological and educational services in schools is presented. It is argued that both traditional school psychologists and university-affiliated psychologists are restricted from influencing change processes in schools. An alternative approach to psychoeducational change is developed; its fundamental feature involves the engagement of internally responsible socioeducational specialists by schools. Several issues bearing upon the viability of the proposed role are discussed. (Author abstract modified)

912. **Reinherz, H.Z. (1982). Primary prevention of emotional disorders in school settings.** In H.C. Schulberg & M. **Killilea (Eds.),** ***The modern practice of community mental health*** **(pp. 445–466). San Francisco: Jossey-Bass.**

The school as a major setting for primary prevention activities is discussed in this article. The four primary targets for preventive work in schools are children, school personnel, parents, and the school environment. School-based preventive interventions involving each of these targets are briefly reviewed and examined. Finally, the status and future of primary prevention in schools is discussed. The author stresses the need for more longitudinal research evaluating the effects of preventive interventions.

913. **Taintor, Z.C. (1976). What the schools can do to promote mental health.** ***Journal of School Health, 46,*** **86–90.**

An analysis of what public schools can do to promote mental health is presented. It is stated that most school activities fit into one or more of the following four roles: classification, education, socialization, and therapy. Once this diversity of function is formally articulated, mental health can be fostered by applying public health concepts of primary, secondary, and tertiary prevention. These three forms of prevention are defined, their potential for improving mental health in the school system is described, and pilot programs involving their application are discussed. It is concluded that the aim of the school system is to provide the best environment for the development of children into adults, and that this requires providing the best education possible with the minimum of covert conflicts between the four functions.

914. **Tanner, L.N., & Lindgren, H.C. (1971).** ***Classroom teaching and learning: A mental health approach.*** **New York: Holt, Rinehart and Winston.**

A mental health approach to classroom teaching is presented. The school is identified as a strategic institution of society. With this groundwork, ways in which the school can effectively operate in a preventive role are noted. Chapters include the impact of the teacher, good and bad elements of the curriculum movements of the 1960s, ways of individualizing instruction, learning the characteristics of various social classes and making curricular and methods accommodations to them, improving relations with the disadvantaged, altering marking and grading procedures, and building better relationships with parents and community.

915. **Todd, K.R.P. (1973).** ***Promoting mental health in the classroom.*** **(DHEW Pub. No. (ASM) 73-9003). Washington, DC: U.S. Government Printing Office.**

This handbook is designed to serve as an aid to teachers. The chapters are intended to promote the development of ideas, attitudes, and skills while producing change in the behavior of participants (teachers) towards children. The booklet is divided into two sections. The first section provides a framework for the understanding of behavior. The second section gives guidelines for effectively changing student behavior in the classroom, enhancing teacher-student communications, and improving intergroup relationships.

916. **Wonderly, D.M., & Jessie, S.C. (1974). Prevention: Systems intervention, an alternative model for school psychology.** ***School Psychology Digest, 3,*** **55-66.**

An alternative model for school psychology--Prevention: Systems Intervention (PSI)--is described, including both a school curriculum component based on an organismic model of human motivation and an organizational intervention plan. The PSI paradigm qualifies as a primary preventive approach because it deals with public and private institutions that systematically affect personality development at a point prior to the emergence of symptoms. Several of the theoretical assumptions on which it is based are considered, including the Holonic theory of motivation, and details of the program are specified. The PSI model is predicated on the belief that by creating a synergistic relationship between school and community, results will be far superior to those based on separate efforts by either group. The PSI program for school psychology emphasizes selected aspects of systems analysis that are commonly misinterpreted, including function, component, and feedback.

917. **Zimiles, H. (1967). Preventive aspects of school experience. In E.L. Cowen, E.A. Gardner, & M. Zax (Eds.), *Emergent approaches to mental health problems* (pp. 239–251). New York: Appleton–Century–Crofts.**

Because schools exercise a psychological influence on students, they can become an active force in preventive mental health. Research of the Bank Street College on the psychological impact of school experience is described as an effort to systematically study the effects of schooling. Schools were selected to vary along a modern–traditional continuum, and, further, various school children were matched on a set of socioeconomic characteristics. Differences in the children were found in a number of areas, including adult-like responses in those from more traditional schools, attitudes toward school, and, across all schools, a number of gender differences. In concluding and framing questions for further research, the author cites the importance of studying the effects of such high-impact environments as schools as a necessary prelude to the design of preventive interventions.

See also: 11, 36, 39, 61, 62, 64, 67, 88, 90, 98, 104, 105, 124, 172, 193, 198, 199, 200, 204, 206, 234, 237, 258, 260, 269, 273, 291, 309, 318, 319, 340, 395, 425, 435, 439, 445, 446, 447, 448, 463, 464, 469, 470, 471, 472, 473, 474, 475, 476, 477, 481, 483, 484, 485, 486, 487, 490, 494, 499, 504, 505, 512, 515, 521, 522, 524, 530, 533, 543, 545, 624, 633, 697, 732, 733, 745, 747, 786, 823, 853, 895, 936, 950, 995, 996, 998, 1000.

C. Descriptions of Prevention Programs in Other Settings

918. **Aberle, D.F. (1950). Introducing preventive psychiatry into a community. *Human Organization*, 9, 5–9.**

This paper describes the implementation of preventive psychiatry in a community. The aims of the team, headed by Dr. Erich Lindemann, included not only the development of preventive services, but also the creation of collaborative relationships with schools and churches, assessment of the extent of emotional problems in the community, and a study of how the community responded to the project. The execution of community research and the effort to use a multidisciplinary rather than psychiatric approach were additional purposes of the project. Relationships with the community involved such activities as efforts to find housing for the project, which helped clarify community attitudes and vested interests, and committee and contact work with various community groups and organizations to provide information about the project and learn about community resources. Various conclusions and recommendations are offered, including the importance of awareness of the sociocultural setting; general knowledge about interpersonal relations, personality, and motivations; and the value of the development of a "Case Book" on the process of implementing the project.

919. **Bowler, W.M. (1980). Industrial prevention: A good investment. *Innovations*, 7, 23.**

An industrial prevention program implemented in a catchment area on the Pennsylvania/New York border is described. The program was offered to managers by a local consultation and education agency in the form of a comprehensive training package for local industries, and was targeted at middle management supervisors and foremen. Topics included methods of coping with stress, understanding employee behavior, motivation, listening skills, crisis intervention theory, and problem-solving techniques. Data from participant evaluations suggest the success of the approach in promoting positive attitudes and management techniques.

920. **Chase, M.M., Heung, P., Shoom-Kirsch, D., & Waldie, L. (1979). A survey of prevention activities in a metropolitan city. *Canada's Mental Health*, 27, 12-14.**

This article is based on the assertion that the planning of prevention programs for children, to be most useful, should take place with the knowledge of existing programs and the subsequent identification of gaps. Efforts to gather such information from a stratified random sample of agencies in North York, Toronto, Ontario, and Cordova are described. Eight types of existing prevention programs were identified, including programs for high-risk families and children, crisis intervention, anticipatory guidance, public education about mental health, mental health training for other professionals, community development programs, social change activities, and fact finding and needs assessment. Lowest emphasis is given social change activities and fact finding. Most of the program originated because "someone within the agency" felt they were needed. Various means of disseminating information on these programs to the public were noted. In conclusion, the importance of gathering baseline information as a prelude to planning is stressed.

921. **Fields, S. (1976). Primary prevention: II. Succor in the shopping center.** ***Innovations, 3*****, 12-16, 18.**

A report is presented of the implementation of a mental health services program in San Mateo County, California, serving a community of 160,000 lower and lower-middle income whites with black, Latino, and Asian minorities. The services include a child development course, kindergarten entry class, parent-child family course, and couple communication course, with emphasis on normal developmental processes. It is believed that in the 10 years since their implementation, these innovative services have proved to be prevention models that could be initiated easily without elaborate budget and administrative adjustments.

922. **Gump, L.R. (1973). The application of primary prevention mental health principles to the college community.** ***Community Mental Health Journal, 9*****, 133-142.**

This article discusses some aspects of consultation entry and the development of consultative resources through presentation of a preventive mental health consultation that utilized a laboratory learning design for large groups in a college parent orientation program. Groups of 100 to 200 parents explored their reactions to such simulated crises as drug use and abortion. The uses of laboratory learning models in preventive mental health with large groups for a college community, particularly when entry into a client system is tenuous, are among the topics discussed.

923. **Hasan, K.Z. (1979). Child mental health in primary health care.** ***Carnets de l'Enfance, 47-48*****,** 91-101.

The author outlines a mental health program for community workers dealing with six common disorders. For each disorder the outline covers easily identifible symptoms, causes, prevention, treatment, and personnel training. In the past, mental health has been considered a matter for specialized professionals. The suggested approach is based on a recognition that prevention and treatment measures for mental disorders are integral parts of a primary health care strategy founded on community-based services. ©APA.

924. **Keepes, B. (1977). The University of Evansville takes advantage of preventive action for mental health.** ***College Student Journal, 11*****,** 36-42.

Results from a survey of undergraduate attitudes in the area of available counseling services at the University of Evansville are reported. The most striking finding was the underutilization of and lack of information about the University of Evansville Guidance and Counseling Center. Students responded positively when asked of their opinion about using a student-operated counseling center if one were available on the campus. A proposal for this type of center is presented and its preventive value discussed.

925. **Kelly, L.D. (1982). Between the dreams and the reality: A look at programs nominated for the Lela Rowland Prevention Award of the National Mental Health Association.** ***Journal of Primary Prevention*****, 2, 217-234.**

The 67 programs nominated for the 1980 Lela Rowland Prevention Award are discussed. Twelve outstanding programs are described individually. All programs are applauded for their efforts and accomplishments; more scientific evaluation and assessment of prevention programs is recommended in order to demonstrate that prevention is effective at accomplishing its goals. (Author abstract) ©Human Sciences Press.

926. **Kiesler, F. (1973). Programming for prevention.** In B. Denner, & R.H. Price (Eds.), ***Community mental health: Social action and reaction*** (pp. 101-111). New York: **Holt, Rinehart, and Winston.**

In an effort to provide a mental health program for 68,000 people in 3 rural northern Minnesota counties, with no mental health specialists whatsoever, the governments of these counties hired 3 professional staff members: a psychiatrist, a clinical psychologist, and a psychiatric social worker. The need was originally conceptualized as a need for direct psychiatric services. These professionals began their involvement by determining who had been taking the responsibility for mental health problems before the "specialists" had arrived. Systematic inquiry showed that doctors, lawyers, court personnel, school administrators and counselors, welfare case workers, and public health and school nurses had done this job. Instead of having these "firing-line" professionals surrender their mental health role to the mental health specialists, the mental health professionals decided to help them increase their proficiency in the role through consultation. Not only has this provided more help for a greater number of people, but it was determined that consultation cost the meagerly budgeted mental health center one-tenth the cost of providing direct clinical services. Having succeeded in creating and maintaining a system of direct services with greater proficiency than existed before, the mental health specialists turned their attention toward prevention. This was initially attempted by using professional education programs that emphasized looking beyond the mental health problems of a group member to the enhancement of mental health in the group as a whole. A method of community action is proposed. It is concluded that such programs are the avenue to reduction in prevalence and incidence of mental health problems.

927. **Kysar, J.E. (1966). Preventive psychiatry on the college campus. *Community Mental Health Journal, 2,* 27–34.**

American colleges lose half their students in the four years after matriculation. This high attrition rate with its waste of brain power and cost in human well-being suggests that our institutions of higher education are not very conducive to optimal development of students. It is postulated that in half or more of all the dropouts and flunkouts from American universities, psychosocial difficulties are an important factor in the failure. Preventive psychiatric measures on the campuses could reduce both educational losses and future psychiatric casualties. These preventive measures and the role of mental health professionals in colleges are elaborated.

928. **Lombardi, J.S. (1974). The college counseling center and preventive mental health activities. *Journal of College Student Personnel, 15,* 435–438.**

The author studied the resources that 128 counseling centers assigned to preventive and remedial activities on both a present and an ideal basis. Under ideal conditions, the sample centers reported that they would devote 34 percent of their resources to preventive activities as opposed to the present 25 percent. It appears, even in an ideal situation, that college counseling centers are not prone to dramatically altering their mission. ©APA.

929. **McKenzie, D.J. (1977). Family court counselling—one year after. *Mental Health in Australia, 1,* 196–198.**

This article traces the origin and development of the Family Court of Australia, established on January 5, 1976, and designed to serve a primary prevention function focusing on the mental health of children and the grief and separation reactions of adults. A general system for court counseling is being developed that includes subsystems dealing with client management, policy, information, public relations, interface among the systems, evaluation, and training. ©APA.

930. **Nelson, S.H., Batalden, P.B., Kraft, D.P., Stoddard, F.J. (1974). Preventive mental health programming for a nonhealth agency. *American Journal of Psychiatry, 131,* 419–422.**

A preventive mental health program, introduced in a nonhealth agency, the Job Corps, is discussed. It is felt that, in order to introduce and maintain a preventive mental health program in an agency such as the Job Corps, certain requirements must be followed: recognition of the goals of the organization, selection of personnel on the basis of proven past experience or special talent, and responsiveness to the youthful high-risk minority population the agency serves and to the staff that works with them. The ways these requirements were fulfilled and the effectiveness of the mental health program are described. (Author abstract modified)

931. **Reissman, F., & Hallowitz, E. (1967). The neighborhood service center: An innovation in preventive psychiatry.** ***American Journal of Psychiatry, 123,*** **1408–1413.**

Directed toward low-income urban groups, the neighborhood service center is designed to detect pathology as it is expressed in the concrete problems of living often related to welfare, housing, and employment and also to more personal emotional life stress. The center does not require appointments, has no waiting list, avoids an office atmosphere, shortens and informalizes intake procedures, and tries to help people at the point of crisis. Such psychosocial first aid is administered mainly by indigenous nonprofessionals who aim to develop techniques of individual self-help as well as to promote greater social integration and cohesion in the community.

932. **Robertson, B. (1968). Primary prevention: A pilot project.** ***Canada's Mental Health, 16,*** **20–22.**

This article describes a primary prevention project in Canada. A twofold goal is described that includes increasing the general level of attention in the community to the full range of human needs, and promoting positive and continuing social relationships between both groups and individuals to increase community support and overall community integration. First, information about the community was gained by establishing a clearinghouse for persons with psychological problems. Data suggested that many persons felt that there was no one to turn to. This information was acted upon through outreach to key persons such as ministers, teachers, and public health nurses. The program coordinator served as a mental health consultant in this process. Feedback at this stage was positive; community caregivers were increasingly sought out by persons in need of help. In addition, numerous indications of increased community good will are mentioned.

933. **Sartorius, N. (1980). The research component of the W.H.O. health programme.** ***Psychological Medicine, 10,*** **175–185.**

The author describes five areas of research included in the World Health Organization's mental health program: (a) development of a common language; (b) specific clinical, biological, and social characteristics of widespread mental and neurological disorders and psychosocial problems; (c) development of methods of treatment and prevention; (d) provision of care; and (e) psychosocial aspects of general health care and groups at increased risk for mental disorders. ©APA.

934. **Tableman, B. (1980). Prevention activities at the State level. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy, and practice* (pp. 237–252). Beverly Hills, CA: Sage.**

Prevention activities begun in 1975 in Michigan are described. The programming has as its essential goal the maximization of coping capabilities and support systems in high-risk populations. High-risk populations, defined in terms of a common demographic or experiential variable that has been shown to be correlated with high rates of deviant behavior, are recruited. This definition and recruitment process uses a body of information derived from clinical and epidemiological studies and has proven to be a crucial issue in prevention programming. Access to high-risk populations in many cases has meant connecting with ongoing service delivery systems such as schools, courts, and hospitals. Issues needing resolution in the Michigan program include reasonable approaches to evaluation and transfer from project funding to the ongoing budget.

935. **Wallinga, J.V. (1982). Human ecology: Primary prevention in pediatrics. *American Journal of Orthopsychiatry, 52*, 141–145.**

The author describes a hospital setting specifically designed and furnished to meet the needs of pediatric patients and their families. Familiarization of the child with the hospital, support of parents, and cooperation between medical and mental health staff are central features of the system. The involvement of the health center personnel in the creation of an environment that fosters emotional sensitivity and responsiveness is emphasized. ©APA.

936. **Zax, M., & Specter, G.A. (1974). *An introduction to community psychology*. New York: Wiley.**

While this book presents an overview of the field of community psychology, two chapters explore the topic of primary prevention. "Primary prevention in the schools" first discusses the school as a site for primary prevention and highlights several value issues involved. Next, a variety of exemplary prevention programs are described, including programs emphasizing intervention in the total school atmosphere, programs aimed at curricular improvement as a means of promoting positive mental health, and programs to modify teaching techniques to promote better mental health. "Prevention in the college community" describes a variety of research/intervention projects designed to improve the mental health of college students, though many of the projects do not involve *primary* prevention.

XVIII. Developing, Coordinating, and Evaluating Primary Prevention Programs

Articles involving the development of primary prevention programs, the coordination of activities among prevention programs, and the evaluation of preventive interventions are listed in this section.

A. Development

937. **Cherniss, C. (1977). Creating new consultation programs in community mental health centers: Analysis of a case study.** ***Community Mental Health Journal, 13*****, 133–141.**

The author discusses a primary prevention program, initiated in a community mental health center, that never became fully operational. Analysis suggests that failure to include recipients in initial planning, an unrealistic timetable, insufficient institutional support for innovation, the project leader's organizational marginality, and the institutional constraints created by commitment to direct treatment of troubled individuals were factors that contributed to the project's failure. Several recommendations are presented, the most important one being that systems-oriented preventive mental health work should be based in a separate institution. ©APA.

938. **Feldman, R.E. (1979). Collaborative consultation: A process for joint professional-consumer development of primary prevention programs.** ***Journal of Community Psychology, 7*****, 118–128.**

The author describes the collaborative consultation process, both conceptually and through illustrative examples; demonstrates that collaborative consultation adheres to mental health consultation conventions, while combining features of "consultation" with those of "collaboration"; provides somes guidelines on learning phases for professionals; and suggests approaches for extending and evaluating the collaborative consultation process. ©APA.

939. **Felner, R.D., & Aber, M.S. (1983). Primary prevention for children: A framework for the assessment of need. *Prevention in Human Services, 2,* 109–122.**

This paper discusses the role of needs assessment procedures in the development of effective primary prevention strategies for children and youth. A number of techniques that may be employed in the assessment of need for such services are presented and their strengths and limitations for such application are discussed. Particular problems for needs-assessment planning and implementation stemming from differences in the goals and objectives of preventive, as opposed to more traditional, mental health services for children are elaborated, and possible strategies for their resolution are suggested. (Author abstract) ©The Haworth Press.

940. **Forquer, S.L. (1982). Planning primary prevention programs: A practical model. *Journal of Children in Contemporary Society, 16,* 69–78.**

The author proposes a model for primary prevention activity planning that provides the practitioner with a framework for identifying variables affecting a population, a means for assessing which variables to address, and a structured approach to planning preventive interventions. The limitations of the model appear to be current limitations of the field. The technology for weighing risk factors and stressors and the quantification and weighing of skills and supports is under development. ©APA.

941. **Goldston, S.E. (1981). Messages for preventionists. In J.M. Joffe & G.W. Albee (Eds.), *Primary prevention of psy- chopathology, Vol. 5: Prevention through political action and social change* (pp. 334–340). Hanover, NH: Univer- sity Press of New England.**

This article was an invited paper summarizing the author's perceptions of the fifth Vermont Conference on the primary prevention of psychopathology. In particular, the article is addressed to the concerns of mental health professionals who are involved in planning and carrying out primary preventive interventions and who may wonder what the theme of the conference, prevention through political action and social change, means for them. The author offers seven "messages" for these preventionists: (1) A need exists to define clearly the roles, boundaries, and limitations of mental health workers. (2) Primary preventionists have the capacity to redress some stressful and damaging environmental conditions, even those linked with excessive imbalances in power. (3) What may appear to be commonsensical may be perceived otherwise. (4) systems can be changed both through "folkways" and "stateways." (5) Needs exist to maximize the prevention potential in relevant agencies in both the public and private sectors. (6) There should be more concern for solving problems than for the politics of problems. (7) Prevention demands passion and commitment.

942. **Klein, D.C., & Goldston, S.E. (1977). Design and implementation of the pilot conference. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 3–10). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Goverment Printing Office.**

The design and implementation of the Pilot Conference on Primary Prevention held April 2 through 4, 1976, under the auspices of NIMH and the National Association for Mental Health are reviewed. The conference was designed for administrators and planners of local community mental health programs, particularly community mental health centers (CMHCs), and sought to address concepts of CMHC accountability, a dual focus on prevention and treatment, identification and intervention for high-risk populations, and program evaluation and replicability. Research undertaken prior to conference planning is reviewed, and guidelines for selection of conference participants and faculty are presented. Elements of conference design included: (1) feedback issues raised by a preconference survey; (2) opening presentations providing a foundation of information on the field of primary prevention, basic strategies, and evaluation; (3) concurrent workshops on primary prevention for target groups, agency strategies for programming, evaluation funding and administration, and community involvement.

943. **Klein, D.C., & Goldston, S.E. (1977). Recommendations stemming from the NIMH/NAMH pilot conference on primary prevention. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 141–147). (DHEW Pub. No. (ADM) 77–447).**

A series of recommendations for future conferences in primary prevention in mental health, arising from the NIMH/NAMH conference model and the April 1976 Pilot Conference on Primary Prevention, are presented: (1) Five additional regional conferences utilizing a modified version of the model should be held within the next two years. (2) Minor changes in model design should allow more informal time and reduce conference intensity. (3) Model replication should be handled on a national level by a single organization. (4) Conference development should be coordinated with appropriate regional citizen and professional groups. (5) Successive conferences should be conducted in the context of related efforts to ensure continuing focus of energy and resources at the local level. (6) A modest fee for participation should be established. (7) A national stance supporting increased emphasis on primary prevention in mental health should be taken.

944. **Levine, H.O. (1975). Some current issues in primary preventive psychiatry. *Mental Health & Society, 2,* 248–255.**

This article examines some of the issues involved in conceptualizing, constructing, communicating, and operating a program of primary psychiatric prevention. The discussion is based on a series of visits to Nova Scotia and Israel and on personal observations from 20 years of psychiatric practice, teaching, and consulting. Cognitive and affective issues among the four groups usually involved in such programs (i.e., government funding and planning authorities, senior and junior professional staff, field professional staff, and participating and nonparticipating community residents) and some of the ultimate effects of these on the final content and operation of programs are discussed. ©APA.

945. **National Institute on Drug Abuse (1981). *Volume I: Prevention planning workbook*. (DHHS Pub. No. (ADM) 81–1062). Washington, DC: U.S. Government Printing Office.**

This first volume in a two-volume series deals primarily with the prevention of drug abuse. This volume details eight steps of a systematic, prevention planning process. These steps include assessing needs, generating problem statements, identifying goals, setting objectives, identifying activities to meet objectives, identifying resources, and developing an evaluation component. These steps have general utility in the planning of mental health prevention programs as well.

946. **National Institute on Drug Abuse (1981). *Volume II: A needs assessment workbook for prevention planning*. (DHHS Pub. No. (ADM) 81–1061). Washington, DC: U.S. Government Printing Office.**

This second volume in a two-volume series discusses in detail the steps involved in conducting a prevention needs assessment. This workbook is intended to assist prevention program planners prepare for a needs assessment, choose the appropriate data-gathering technique, analyze the data, and utilize the findings in prevention program planning. It describes five of the most commonly used needs assessment methodologies and depicts the application of these techniques through case studies. In addition, study aids for the reader, data collection instruments, and specific prevention examples are included in the text to enhance the explanation and utilization of the prevention needs assessment techniques presented.

947. **Offord, D.R. (1982). Primary prevention: Aspects of program design and evaluation.** ***Journal of the American Academy of Child Psychiatry, 21,*** **225–230.**

The author provides a background for planning primary prevention studies and evaluating existing primary prevention literature. Types of primary prevention programs, uses of unobtrusive data, causal chains, and conditions (e.g., antisocial behavior and mental retardation) meriting primary prevention efforts are discussed. ©APA.

948. **Raber, M.F. (1977). Involvement of the community in primary prevention. In D.C. Klein, & S.E. Goldston (Eds.),** ***Primary prevention: An idea whose time has come*** **(pp. 103–105). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

Strategies for facilitating community involvement in primary prevention programs by the Prairie View Mental Health Center are listed. These include: mental health board education, luncheon groups and community/staff study groups, community resource councils, teacher training programs, family life seminars, employee assistance programs, socialization groups, community and staff leadership training, and growth services. The importance to the success of primary prevention programs of enlisting community support and involvement is emphasized.

949. **Rae–Grant, N. (1979). Prevention: A multifaceted approach requiring multidisciplinary input.** ***Canada's Mental Health, 27,*** **3–4.**

While interest in prevention is growing in Canada, the U.S., and Britain, the tasks of implementing prevention programs are multifaceted and require the cooperation and collaboration of many different disciplines. Implementation of prevention programs depends on the definition of prevention, which includes two distinct aspects: (a) efforts to modify stressful environments and (b) efforts to strengthen the coping capacities of individuals. Any point in the life cycle constitutes a relevant time for preventive interventions, depending on the particular issues addressed. Examples of potential programs––both person–based and environment–based–– are given in the context of the need for varied disciplines to contribute their distinctive expertise and to collaborate across disciplinary and agency lines.

950. **Santos, R.R. (1977). Developing primary prevention programs with major community institutions. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 93–99). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

The development of a primary prevention program for children by the Wilkes-Barre community mental health center (CMHC), in conjunction with the public school system, is summarized. Program focus involved working with adults in the school system to provide preventive transitional and crisis services. Development involved: (1) staff selection for multidisciplinary teams in the areas of infancy and early childhood, childhood, and adolescence; (2) precontact attitude and program need/availability research and program conceptualization; (3) contacting school administrators; (4) program channeling and negotiation; and (5) planning by school administrators. The programming process involved special parent and teacher education programs aimed at integrating the service into the school system. The parent and teacher role shifts from service recipient to provider are highlighted.

951. **Signell, K.A. (1983). Starting prevention. *Community Mental Health Journal, 19,* 144–163.**

This article provides basic, practical guidelines for starting prevention work. It draws upon 10 years' experience of professional staff members at a community mental health center. Difficulties that stand in the way of prevention are first discussed. The difficulties include professional habits, defenses, and taboos, as well as lack of theory, training, and institutional support. The main body of the article provides examples of effective and ineffective ways of starting prevention, that is, promoting mental health in the community. Recommendations are made for using a normal developmental life-crisis framework, and starting small action models that can later be generalized to diverse settings and have potential for long-lasting effects in the community. (Author abstract) ©Human Sciences Press.

952. **Stuehler, Jr., G., & O'Dell, S.T. (1979). The manageable approach to college health services planning. Part II. *Journal of the American College Health Assocation, 28,* 98–103, 105–908.**

The strategic and operational planning that is necessary in college health services is depicted, and the manner in which such planning can be accomplished in 10 weeks through a mangeable approach is delineated. Basic concepts and components of the approach, which emphasizes personal growth, prevention, and treatment rehabilitation, are described, and guides to the success of each stage are included. A major component of health promotion services is stress control and personal fulfillment through meditation and yoga, biofeedback, autohypnosis, assertiveness, communication skills, gestalt training, and counseling on human sexuality. The prevention perspective is emphasized in all treatment activities, including a focus on preventive medicine in continuing education, rape prevention, and education. (Author abstract modified)

953. **Zautra, A., & Sandler, I. (1983). Life event needs assessments: Two models for measuring preventable mental health problems. *Prevention in Human Services, 2*, 35-58.**

In this paper, two complementary models are presented to guide needs assessment efforts for prevention programs. Each of these models focuses on events as the core elements in the study of human needs. One model is concerned with the nature and impact of stressful events on psychological distress; the other is concerned with personal growth and development that may arise through integration of positive life experiences. After the models are described, suggestions are provided on how best to use them when conducting a prevention-oriented needs assessment. (Author abstract) ©The Haworth Press.

See also: 1, 35, 50, 79, 94, 173, 191, 261, 265, 278, 304, 320, 365, 404, 507, 631, 679, 685, 710, 788, 795, 802, 851, 852, 879, 887, 898, 920, 926, 947, 963, 980, 983.

B. Coordination of Prevention Activities

954. **Giesen, A.R. (1981). Interagency cooperation in preventive efforts. *Advance, 31*, 20-21.**

The status of mental health prevention programs in the State of Virginia is reviewed. Past efforts to organize and implement various plans are cited. In 1980 an interagency task force was established to develop effective prevention and public awareness programs relating to mental health, mental retardation, and substance abuse. The importance of interagency cooperation for the success of these programs is emphasized.

955. **Hollister, W.G. (1977). The management of primary prevention programs. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 106–111). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

An overview of primary prevention program development and maangement is summarized. A systems analysis approach to outline, define, set up, operate, monitor, maintain, evaluate, and improve the program is recommended. Specific management tasks in approximate chronological order include: (1) assessment and verification of needs; (2) development of sanction to plan and develop; (3) implementation planning; (4) design and implementation of feasibility trials of each prevention project; (5) establishment of necessary staff organization; (6) designation of program leader; (7) final presentation of total program to obtain mandate; (8) selection and hiring of new staff; and (9) establishment of management and operation processes including governance, financing, research and analysis procedures, monitoring mechanisms, and staff development.

956. **Nowlis, H.H. (1981). Coordination of prevention programs for children and youth. *Public Health Reports, 96*, 34–37.**

The current movements toward prevention of physically, socially, and psychologically destructive behaviors through the promotion of positive growth and development, self-esteem, interpersonal skills, and self-realization among children and youth is examined, and issues that cause conflict between various agencies involved in prevention programs are discussed. Category-based constraints that are influential in prevention programming for children and different views on the enhancement of human development are treated. The specific contributions of the Alcohol and Drug Abuse Education Program of the U.S. Department of Education are also reviewed. It is concluded that various State, local, and Federal agencies should examine their programs and procedures to identify areas for cooperative effort in the provision of services that will enhance personal and social functioning among young people.

See also: 185, 187, 188, 929.

C. Evaluation

957. **Beiser, M. (1982) Evaluating primary prevention programs: Models and measures. In S.M. Manson (Eds.), *New directions in prevention among American Indian and Alaskan native communities* (pp. 301–322). Portland, OR: Oregon Health Sciences University.**

This article discusses models of evaluation activities as they involve the relationships between program needs and methods of evaluation, using examples of treatment and prevention programs with American Indians and Alaskan Natives. The author asserts that the expected products of evaluation should determine the methods used. Products can include implementation statements, formative statements, and summative statements. Implementation products take the form of answers to such questions as "who should constitute the target group for prevention?" Formative statements involve a concern with process in programs and the feedback of data for the purpose of program improvement. Summative statements involve the evaluation of progress outcomes. The author further argues for the inclusion of multiple measures in assessing the impact of prevention programs, particularly in view of the difference between reducing a disorder or "bad state" and the promotion of health in a "good state."

958. **Bickman, L. (1983). The evaluation of prevention programs. *Journal of Social Issues, 39*, 181–194.**

The author begins by asserting that the future of prevention programs is tied to demonstrations of their effectiveness. Various barriers to the evaluation of prevention programs are then described, including attitudinal issues (e.g., the assertion that prevention programs cannot be evaluated because one cannot logically assess the absence of a condition) and conceptual barriers such as a lack of theory, difficulty in defining the criteria for success, and the researcher's lack of control over the implementation of the program. One particularly central problem is what the author calls "the problem of extended chains of causal linkages" between program implementation and program effects. Various methodological issues are then addressed, including monitoring program integrity over time, the importance of measurement, establishing sensible comparison groups, and the problem of low base rates. The author concludes with an affirmation of the importance of evaluation in supporting prevention programs.

959. **Bloom, B.L. (1968). The evaluation of primary prevention programs. In L.M. Roberts, N.S. Greenfield, & M.H. Miller (Eds.), *Comprehensive mental health* (pp. 117–135). Madison, WI: University of Wisconsin Press.**

The author presents a comprehensive discussion of the methods and problems of mental health program evaluation, with particular attention to the evaluation of primary prevention programs. He describes the types of evaluation studies and the importance of specificity in selecting targets, objectives, and criteria for success. He then presents 14 questions to be considered in the evaluation of a primary prevention program. Some public health concepts are discussed along with definitions (e.g., prevalence and incidence) and a three-part framework of primary preventive efforts (community-wide, milestone, and high-risk-group programs). Finally, it is advocated that 5-10 percent of every mental health agency budget should be allocated to evaluative and research efforts.

960. **Bloom, B.L. (1977). Evaluating achievable objectives for primary prevention. In D.C. Klein, & S.E. Goldston (Eds.), *Primary prevention: An idea whose time has come* (pp. 49–60). (DHEW Pub. No. (ADM) 77–447). Washington, DC: U.S. Government Printing Office.**

The evaluation of achievable objectives in community mental health primary prevention programs is discussed. Characteristics of the community mental health movement and a brief critique of service delivery gaps are presented. Evaluation basically involves the determination of the degree of program success in fulfilling predetermined objectives. Aspects of evaluation include: advance specification of the program and its objectives, presentation of evidence that the program is the cause of change, and determination of success based on measurable criteria. Types of evaluation include program description, self-reports of service recipients, judgmental evaluation effectiveness by service providers or outside experts, and analysis of objective community data without recourse to intervening or interpretive judgments. Considerations for administrators in developing primary prevention evaluation programs are also listed.

961. **Flanagan, J.C. (1971). Evaluation and validation of research data in primary prevention, *American Journal of Orthopsychiatry, 41*, 117–123.**

Some of the problems that commonly arise in interpreting research data in the field of primary prevention are reviewed, and the procedures that must be followed for the results to be accepted as valid evidence of relationships are summarized. It is found that valid research findings require (1) a random or representative sample of sufficient size; (2) a statement of the experimental treatment and the anticipated effect of the treatment; (3) criteria representative of the ultimate objective of reduced incidence rates; (4) simple, easily understood statistical techniques with replication as the best test of significance; and (5) an interpretation that summarizes not only the findings but their practical significance for various situations.

962. **French, J.F. & Kaufman, N.J. (Eds.) (1981). *Handbook for prevention evaluation: Prevention evaluation guidelines.* (DHHS Pub. No. (ADM) 81-1145). Washington, DC: U.S. Government Printing Office.**

This 250-page book provides guidelines on how to carry out evaluation of a primary prevention program. Individual chapters contain discussions of: (1) models for evaluation, (2) process evaluation--indicators and measures, (3) outcome evaluation--indicators and measures, (4) impact evaluation--indicators and measures, (5) process methodology, (6) outcome studies in evaluation research, (7) methods for the study of impact, (8) evaluation research design and data analysis, and (9) utilization and transfer of evaluation results. It is published by the National Institute on Drug Abuse but has applicability to mental health program evaluation concerns.

963. **Heller, K., Price, R.H., & Sher, K.J. (1980). Research and evaluation in primary prevention: Issues and guidelines. In R.H. Price, R.F. Ketterer, B.C. Bader, & J. Monahan (Eds.), *Prevention in mental health: Research, policy and practice* (pp. 285-313). Beverly Hills: Sage.**

The authors' aim is to review the conceptual and methodological difficulties associated with primary prevention research. Among the conceptual difficulties are (1) problems in specifying how prevention goals can be operationalized and (2) a lack of knowledge concerning the etiology of mental disorders. The authors review some of the methodological impediments to research in primary prevention, e.g. the difficulty of doing research in applied settings and the problems associated with the prevention of low base rate disorders. Guidelines for the development and evaluation of prevention programs are offered. The authors state three components in a prevention program that need better specification: (1) the prevention target, (2) the program or intervention, and (3) the expected outcome. A discussion of the political impediments to primary prevention research is given. It is stressed that prevention research requires a long-term policy commitment at the Federal level. The authors believe it will be difficult to sustain public interest and funding of primary prevention efforts without the accumulation of some supporting evidence. The authors state that the conceptual and methodological tools exist that can help overcome the paucity of evaluation research on primary prevention programs.

964. **Hermalin, J.A., & Weirich, T.W. (1982). Prevention research in field settings: A guide for practitioners. *Prevention in Human Services, 2,* 31–48.**

The need for research in prevention has never been greater, while the support for such research is declining. A partnership between prevention practitioners and researchers is recommended. To play an active role in this resource network, practitioners must learn more about the applied research process. This paper describes the major phases of that process and discusses the decisions that practitioners must make at each research step. The paper makes recommendations for conducting research on a shoestring budget and emphasizes special problems encountered in field settings. (Author abstract) ©The Haworth Press.

965. **Kelly, J.G. (1977). The search for ideas and deeds that work. In G.W. Albee, & J.M. Joffee (Eds.), *Primary prevention of psychopathology, Vol. 1: The Issues* (pp. 7–17). Hanover, NH: University Press of New England.**

The article discusses the usefulness of primary prevention efforts and recommends several strategies for carrying out research in naturalistic settings. These strategies include: (1) developing a longitudinal time perspective, (2) getting to know and understand the setting research is done in, and (3) paying careful attention to and learning from the research relationship with the host environment.

966. **LeRiche, W.H. (1968). Preventive programmes in mental diseases: Their evaluation. In F.C.R. Chalke, & J.J. Day (Eds.), *Primary prevention of psychiatric disorders* (pp. 69–83). Toronto: University of Toronto Press.**

The author presents certain methods of approach which should be used in the evaluation of programs of primary prevention. The first requirement is a high degree of accuracy in diagnosis. Also necessary is a long-term study of the natural history of mental disorders. A description is given of procedures to use in interpreting and determining death rates and suicide rates from death certificate material, and various difficulties in interpreting mortality rates from these sources are discussed. Three types of survey studies of mental disorders are mentioned: comprehensive area surveys, such as that of Hollingshead and Redlich; selected group surveys, studying certain groups such as students, workers, or army draftees; and longitudinal studies, which represent the most difficult but most valuable type of study.

967. **Lorion, R.P. (1983). Evaluating preventive interventions: Guidelines for the serious change agent. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research, and practice* (pp. 251–271). New York: Pergamon Press.**

The route to the development of the knowledge base necessary for realizing the potential of prevention and bringing to fruition the social change efforts of preventive psychologists is outlined. Core issues discussed include critical flaws in community research historically, basic research principles, what to include when planning prevention research, the politics of field research, and validity and measurement of outcome. The author urges that community psychologists learn from past mistakes and formulate systematic, long-term evaluations.

968. **Maher, C.A. (1980). Evaluating school-community prevention programs: The Program Analysis and Review System. *Journal of Community Psychology, 8*, 276–284.**

A management-oriented system for the evaluation of school-community prevention programs is described. The approach, termed Program Analysis and Review System (PARS), emphasizes a cooperative working relationship between a program evaluator and prevention program manager for the purpose of making informed judgments about the design, modification, maintenance, or termination of a prevention program. PARS has been field tested with a set of school and community prevention programs: a primary mental health program, a home crisis project, parent education, a senior citizen program, a group counseling program, an outreach program for children with school or community adjustment problems, humanistic drug education, and a teacher intervention/prevention program. The system involves three interrelated steps: program specification, program documentation, and program outcome determination. Each step is discussed with regard to justification and purpose, evaluation methods and procedures employed, and evaluation outcomes resulting from application. In addition, a procedure for metaevaluation is outlined.

969. **Maher, C.A. (1981). An evaluation system for school-community prevention programs. *Journal of Primary Prevention, 2*, 101–113.**

A management-oriented system for the evaluation of school-community prevention programs is described, and examples of how the system has been applied to serve program management decisions with primary, secondary, and tertiary prevention programs are provided. The approach, termed "Program Analysis and Review

System (PARS)," emphasizes a cooperative relationship between a program evaluator and prevention program manager in order that informed judgments can be made about program development and improvement. PARS, which was developed by the author in response to a perceived need for management-oriented approaches to prevention program evaluation, has been field tested with school-community prevention programs in Bergenfield, New Jersey, and Somerville, New Jersey, and has been adapted for use in other communities. PARS consists of three interrelated steps: program specification, program documentation, and program outcome determination. (Author abstract) ©Human Sciences Press.

970. **Morell, J.A. (1981). Evaluation in prevention: Implications from a general model.** ***Prevention in Human Services*, *1*, 7–40.**

Evaluation is a many-faceted, rapidly developing process, held together by a common theme: a practical orientation toward using social programs. That practical orientation can be understood in three ways: as a total evaluation system, as a technological endeavor, or as a social research effort that has the intent of being useful as evaluation. There are three basic elements to good evaluation: validity, utility, and theory. Validity and utility must be understood in terms of specific threats to their integrity. The salience of those threats shifts with the context of evaluation activity. Theory is important because powerful evaluation designs cannot be developed, nor can results be interpreted, without an understanding of the dynamics of program action. Each aspect of evaluation--validity, utility, and theory--must be considered relative to four aspects of prevention that pose particular impediments to the conduct of evaluation. Those special characteristics are: the need to mass target prevention programs, the problem of treating people who have not yet manifested symptoms, difficulties in ascertaining when prevention will be most useful, and the need to evaluate prevention programs through long-term observation. (Author abstract) ©The Haworth Press.

971. **Selig, A.L. (1979). Research and evaluation in community-oriented primary programs.** ***Canada's Mental Health*, *27*, 19–23.**

Major issues in research and evaluation of community-oriented programs designed to promote development and prevent emotional dysfunction (primary prevention) are reviewed. Six important issues in research and evaluation of prevention are identified: (1) continuing education of mental health clinicians, (2) definitions of emotional dysfunction, (3) methods of gathering data, (4) isolation of factors in complex environments, (5) the need for longitudinal studies, and (6) structuring realistic expectations. The following aspects of the process of planning for evaluative research are discussed; theoretical orientation, problem identification, goal setting, goal measuring criteria, program planning, program implementation, assessment, and feedback.

972. **Weirich, T.W., & Hermalin, J.A. (1982). Collaborative research in primary prevention: The practitioner-researcher relationship. In F.D. Perlmutter (Ed.), *New directions for mental health services: Mental health promotion and primary prevention* (pp. 93–103). San Francisco, CA: Jossey-Bass.**

The authors assert that the changing economy within which prevention services occur pushes prevention leaders to demonstrate efficiency and effectiveness. Focus on the relationship between practitioner and researcher follows from this need. Researchers provide a variety of skills in assessing program impact and program functioning and generating grant support. This chapter, written primarily for practitioners, outlines several aspects of research that can serve as vehicles for collaboration between practitioner and researcher. Four issues are selected for discussion: "selection of a research problem, assessment of research feasibility and support, initiation of a collaboration with a researcher, and establishment of a positive working relationship between practitioner and researcher." Throughout the discussion of these four issues, the positive value of collaboration is stressed.

973. **Wilson, F.R., & Yager, G.G. (1981). A process model for prevention program research. *Personnel and Guidance Journal*, 59, 590–595.**

A process model for primary prevention program research in the counseling field is presented, and its usefulness in working with specific problem behaviors, role failures, relationship breakdowns, feeling overreactions, and psychological disabilities is described. The model features four essential steps: assessment, goal setting, strategy implementation, and evaluation. Anticipated problems encountered by prevention research at each step of the model are discussed. The primary advantage of the model is seen as its recursive nature. Following each evaluation, subsequent cycles are not only permissible but, in essence, are required. Evaluation yields more ideas for goals and strategies and may even suggest a new assessment of the appropriate need and target population. (Author abstract modified)

See also: 1, 26, 49, 76, 105, 139, 147, 148, 149, 153, 163, 501, 615, 801, 802, 979, 983.

XIX. Training of Individuals to Provide Primary Preventive Services

Articles appearing in this section discuss issues regarding, or descriptions of, the training of individuals to engage in primary prevention activities. Articles are categorized according to whether they involve: (1) the training of mental health professionals such as psychiatrists, psychologists, or social workers; (2) the training of other professionals such as members of the clergy, teachers, or police officers; and (3) the training of nonprofessionals to engage in preventive services.

A. Training of Mental Health Professionals

974. **Brunstetter, R.W. (1970). Community child psychiatry: Description of a training program and comments. *Journal of the American Academy of Child Psychiatry, 9*, 445–461.**

A report on the Children's Service of the Langley Porter Neuropsychiatric Institute is presented. During the past 5 years, this service has provided a course in community child psychiatry, which offers career trainees a limited introduction to the concepts, methods, and problems of community mental health pediatrics. The 2-year course has included a 9-month field trip series involving a suburban community, an urban community, and State agencies. The second year of training involves 8 weeks in Project Headstart; 9 months of agency consultations, treatment reviews, talks before community groups, and community meetings; and seminars in community child psychiatry throughout the year. Project Headstart enabled trainees to observe the workings of a massive experiment in preventive psychiatry as well as the problems of the disadvantaged. After a period of orientation in a variety of agencies (e.g., high schools and child career centers), the trainees function as consultants to the agency and are supervised in the seminar on community child psychiatry.

975. **Dorr, D. (1977). Intervention and prevention: I. Preventive intervention. In I. Iscoe, B. Bloom, & C. Spielberger (Eds.), *Commuity psychology in transition* (pp. 87–93). New York: Wiley.**

As part of the National Conference on Training in Community Psychology held in Austin, Texas, in April 1975, three groups developed training models with intervention/prevention approaches appropriate for community psychologists. This group established guidelines for training programs using a preventive, growth enhancing intervention model. The goal of training was to promote and strengthen the skills needed to deal with environmental demands. Training would emphasize consultation and program development. The training program would integrate individual psychology and sensitivity to social and environmental factors. Research methodology, field experiences, public access skills, and administrative skills would be stressed. A multidisciplinary institute would be the best training site, although psychology departments might also provide training. Program funding could be generated through community service, training grants, and private sector and foundation money. Training could lead to employment in traditional clinical positions, entrepreneurial positions in the private sector or government, and in human service positions not identified with psychologists.

976. **Gerrard, M. (1977). Intervention and prevention: II. Systems analysis and organizational dynamics. In I. Iscoe, B. Bloom, & C. Spielberger (Eds.), *Community psychology in transition.* (pp. 95–98). New York: Wiley.**

This article describes guidelines for a training program in systems analysis and organizational dynamics relevant for community psychologists. Facilitative rather than directive roles with clients are emphasized. The training program would endow people with political savvy and systems level problem-solving skills. Students would have training in assessment, intervention, and evaluation at the organizational and societal levels as well as in a variety of communication and administrative areas. While the program would concentrate on the organizational level, experiences at other levels would be encouraged. Program content would reflect the training setting, faculty interests, and current social and political concerns. Both pure and applied research methodology would be emphasized. A team apprenticeship approach would be taken in field experiences to maximize student contact with faculty/supervisors.

977. **Goldston, S.E., & Padilla, E. (1971). Appraisals of mental health topics covered in public health training. In *Mental health training and public health manpower* (pp. 156–184). (DHEW, Public Health Service Publication #72-9024). Washington, DC: U.S. Government Printing Office.**

The appraisals of the coverage of distinctly identifiable mental health content areas, subject matter, and activities in a public health training context are presented. The mental health topics are organized into three areas, each broadly reflecting components of the scope of public mental health work: (1) a basic area that includes nine topics in personality theory, socialization, and interpersonal relations; (2) a general area that includes 26 topics related to primary prevention techniques of mental health work, administration, and information or content; and (3) a specialized area that includes eight topics concerned with secondary and tertiary prevention of mental illness.

978. Harrison, S.I., & Delano, J.G. (1976). The status of prevention in the education of child psychiatrists. *Child Psychiatry and Human Development*, 7, 3–21.

The status of prevention in the education of child psychiatrists was investigated through a survey of directors of child psychiatric residency programs. Results suggested that, when attention is devoted to prevention in the education of child psychiatrists, it is often ambiguous, haphazard, and minimal. It is thought that the ambiguous status of prevention in child psychiatric education is partly an inevitable consequence of the fragmentation of child psychiatric services reflected in the patterns of residency education. Suggestions for improvement include the implementation of residency programs as part of a comprehensive interrelated network of services ranging from prevention to rehabilitation.

979. Hodges, W.F. (1977). Intervention and prevention. III: The enhancement of competency. In I. Iscoe, B. Bloom, & C. Spielberger (Eds.), *Community psychology in transition* (pp. 99–107). New York: Wiley.

This paper discusses interventive and preventive models of training and the skills needed by community psychologists in the area of competency enhancement. The paper outlines issues rather than designing a specific training model. Enhancement of existing resources and skills both in individuals and communities is emphasized over prevention of specific psychopathologies. Intervention at the highest feasible level (i.e., social environment) is preferred. Training should be provided for community assessors, change agents, agents linking needs to programs, advocates, administrators, and community leaders. Research and evaluation are seen as essential in the development of a knowledge base for intervention and program evaluation. Skills necessary for community intervenors and content areas to be covered are noted. Levels of training could range from paraprofessional to Ph.D. and should cover specialized to general training, the latter incorporating research and theoretical skills.

980. **Kane, R.P., Wiszinkas, E., & Forquer, S.L. (1982). Prevention: Promise of premise? A training program in the primary prevention of childhood mental disorders.** ***Journal of Children in Contemporary Society, 14,*** **91–100.**

This article reports on a National Institute of Mental Health-funded 3-year training demonstration program for caregivers in the primary prevention of childhood mental disorders. Strategies for recruitment of participants, implementation, and evaluation are described. Two major issues are addressed: (a) success in meeting and maintaining initial recruitment objectives and (b) the nature of program impact on participants. It is concluded that the program has been successful in both meeting and maintaining recruitment objectives and in demonstrating positive impact on program participants. Positive impact has been measured by increase in knowledge, job application, and program implementation. Implications for future program replications are discussed. ©APA.

981. **L'Abate, L., & Thaxton, M.L. (1981). Differentiation of resources in mental health delivery: Implications for training.** ***Professional Psychology, 12,*** **761–768.**

The following mental health delivery systems, which include a variety of "movements" or approaches, are briefly differentiated and reviewed: prevention, self-help groups, social-skills training, psychotherapeutic interventions, environmental modification, and community resources. The implications of this differentiation for training in clinical psychology are discussed. ©APA.

982. **Lewis, J.A., & Lewis, M.D. (1981). Educating counselors for primary prevention.** ***Counselor Education and Supervision, 20,*** **172–181.**

The development of skills needed by counselors for primary prevention in mental health is discussed. Primary prevention focuses on lowering the incidence of emotional problems and on promoting positive mental health among people not identified as having any special difficulty, and it involves activities designed to reduce environmental stresses or to build people's competencies and life skills. Educational, program development, and change agent skills are all needed to address these problems. All of these can be learned by the counselor in the context of master's level education or inservice training. If counselors can develop the special skills needed to carry out primary prevention strategies, they may be effective in helping their clients find and maintain the personal and environmental resources they need to ward off problems. (Author abstract modified)

983. **McCulloch, P.C. (1980). The ecological model: A framework for operationalizing prevention. *Journal of Prevention, 1*, 35–43.**

A model is described that was used for training prevention workers and supervisors and for funding prevention program development, implementation, and evaluation. The theoretical basis of the model is briefly reviewed and a description of the content of ecological model training sessions is presented. Training concentrates on the content areas of: (1) understanding patterns of human behavior, (2) community diagnoses and community development, (3) group process and organizational development, and (4) program development and evaluation. Programming is examined in detail. It is suggested that this model provides a concrete framework for operationalizing prevention in community-based, self-help oriented, consumer controlled programs.

984. **Meyer, M.L. & Gerrard, M. (1977). Graduate training in community psychology. *American Journal of Community Psychology, 5*, 155–164.**

The results of a 1975 survey of graduate training programs in community psychology and community mental health are presented. For 62 programs offering master's or doctoral training, formal curriculum components in each of five content areas (community systems and behavior, prevention or promotion of effectiveness, practice of community mental health, research and evaluation, and administration) are reported. Availability of training in six sites (community mental health centers; State hospitals; schools; legal, public health, and social service systems) is also indicated for each program. The number of faculty primarily involved in community psychology or community mental health training and principal sources of financial support for graduate students are described. A list of the 62 programs is provided.

985. **Price, R.H. (1983). The education of a prevention psychologist. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 290–296). New York: Pergamon Press.**

The author considers the next generation of prevention researchers as a critical resource in addressing the gaps in our knowledge base and discusses the issue of how these new researchers are to be educated. A model is proposed for thinking about four interconnected research domains: problem analysis, innovation designs, field trials, and innovation diffusion. Implications of the model for the education of students are discussed in the context of the organizations that house preventive and other psychologists. The author presents ideas for organization and for the relationship between the prevention researcher and the population on behalf of whom he or she conducts research.

986. **Rae-Grant, N.I. (1982). The implications for the training of the child psychiatrist.** ***Journal of the American Academy of Child Psychiatry, 21***, 219-224.

The author argues that the field of primary prevention has a sufficient research base to have come of age, but it is still not yet integrated into child psychiatry training. Barriers include emphasis on the individual, psychopathology, and methods of funding that reinforce direct service rather than prevention. Ways in which an ecological orientation, competence promotion, consultation methods, and applied sciences could be used to broaden the experiences of residents so that they may consider problems and possible preventive interventions not only at the case level but also at the class, community, and cultural levels are suggested. ©APA.

987. **Seagull, E.A.W., & Seagull, A.A. (1979). The talk to lay groups as a method of primary prevention.** ***Journal of Clinical Child Psychology, 8***, 130-132.

Techniques to integrate feeling and behavior in talks before lay groups in order to encourage lay groups to participate in mental health primary prevention are discussed. A well-delivered talk can help audience members change ongoing behavior, anticipate and thus successfully handle developmental crises in family life, or facilitate needed changes in systems or communities. Giving such a talk is a learnable skill, which involves dealing with both affect and with behavior while discovering and meeting audience needs, being prescriptive, using humor and concrete examples, and dealing with audience questions in an empathic and nonthreatening manner. By uncovering expertise within the audience, a speaker can initiate exchanges that may lead to continuing supportive interactions between the audience and the mental health community. (Author abstract modified)

988. **Solyom, A.E., & Greenman, G.W. (1980). Training and primary prevention: Clinical experience with infants and their families as an obligatory part of the child psychiatrist's training.** ***Infant Mental Health Journal, 1***, **76-88.**

A training program for child psychiatrists working with infants and their families is described. The obligatory clinical program at the University of Michigan Medical School consists of following infant and parent development through the first postnatal year. Although the families who volunteer to participate are not selected on the basis of identified problems or risks, intervention was indicated on several occasions. The psychiatrist's function in primary prevention with infants is reviewed.

989. **Staulcup, H.J. (1980). Education in preventive social work: A masters level training program. In H.J. Staulcup (Ed.), *Primary prevention in social work* (pp. 56–70). St. Louis, MO: Washington University.**

The development of a model training program designed to incorporate preventive content and thinking into a master's level program at the George Warren Brown School of Social Work is described. The school of social work's Prevention Speciality Program is designed to develop and implement a model curriculum in which primary prevention is integrated into the total social work curriculum, along with courses on direct practice (secondary prevention) and rehabilitation (tertiary prevention). All students are exposed to preventive content and the preventive orientation to problem-solving through core courses, schoolwide lectures and symposia, and special presentations in courses such as community development and family therapy. Four major components of the program are the curriculum, the practicum placements, meetings of trainees in primary prevention, and information dissemination.

990. **Vanderven, K. (1982). Educating practitioners in primary prevention. *Journal of Children in Contemporary Society, 14*, 81–89.**

The author discusses reasons for lags in preparation of primary prevention (PP) manpower and some PP activities along with knowledge, skills, and attributes necessary to implement them. Specifically, child ecology as a rationale for education in PP, core activities of PP and related professional skills, early childhood intervention, and psychological aspects of physical conditions are discussed. Implications for educational programs and activities are included.

991. **Weinberg, A., & Andrus, P.L. (1982). Continuing medical education: Does it address prevention? *Journal of Community Health, 7*, 211–214.**

To determine whether continuing medical education (CME) courses offer needed information and training in preventive and health education techniques for physicians, the authors surveyed the special CME issues of the *Journal of the American Medical Association*. They conclude that opportunities for physicians to acquire new knowledge and skills in prevention by means of CME courses are at present limited and apparently not growing substantially. They suggest a strategy for enhancing such opportunities. (Author abstract) ©APA.

992. **Zolik, E.S. (1983). Training for preventive psychology in community and acadmic settings. In R.D. Felner, L.A. Jason, J.N. Moritsugu, & S.S. Farber (Eds.), *Preventive psychology: Theory, research and practice* (pp. 273–289). New York: Pergamon Press.**

This chapter presents the current status, successes, problems, issues, and needs in academic and applied training for prevention at the graduate level. An overview is provided of the status of consultation and education programs in community mental health centers and the relation between consultation and education and primary prevention. Various programs are described along with the needs in training programs. The author suggests that needs for development in the academic setting include increased manpower (i.e., faculty resources), approaches to improving training in prevention (such as development of postdoctoral programs), and improved training in systems approaches to prevention and education in mental health epidemiology. The major need in applied settings is for basic survival of those preventive programs.

See also: 63, 124, 146, 165, 189, 205, 210, 242, 244, 252, 319, 336, 508, 590, 603, 617, 631, 647, 834, 837, 840, 893, 894, 923, 951.

B. Training of Other Professionals

993. **Bard, M. (1973). The role of law enforcement in the helping system. In J. Snibbe (Ed.), *The urban policeman in transition*. Springfield, IL: Charles C. Thomas.**

The incorporation of the police as professional members of the helping system of the community is discussed. An experimental program describes how mutual distrust of both institutions can be minimized while they cooperate to serve the community more effectively. The collaboration permitted each agency to remain faithful to its primary mission. The program was conceived as a combination of crime prevention and preventive mental health principles, using policemen as primary crisis intervention agents in family disturbance problems. Volunteer policemen were interracially paired and given intensive training in family crisis intervention techniques, after which they were specially assigned to investigate complaints involving family disturbances. Results of the program were encouraging and suggest that sensitivity training and use of other mental health concepts are effective in preparing the front line police officer to deal with aggressiveness and violence, and that the generalist-specialist model of police patrol is viable. A variety of research implications are evident.

994. **Birenbaum, A. (1974). The pediatric nurse practitioner and preventive community mental health.** ***Journal of Psychiatric Nursing and Mental Health Services*, *12*,** 14–19.

This article discusses five functions that pediatric nurse practitioners are presently providing in various settings. Three of these functions are oriented to primary prevention; (1) influencing the maintenance of parental attitudes and actions related to child health, (2) preparing parents and child for the stresses of hospitalization, and (3) aiding parents in coping with anxieties concerning their child's behavior through increased understanding. The other two functions involve supporting parents in need of therapy and early identification and intervention in cases of potential or actual child neglect or abuse.

995. **Buncab, C.P. (1980). Constraints on school nurse-teachers' performance of preventive mental health activities in elementary schools.** ***Issues in Mental Health Nursing*, *2*,** 17–31.

In a survey of 225 elementary school nurse/teachers and 204 elementary school principals, the extent of involvement of the nurse/teachers in preventive mental health activities was determined. The activities performed by school nurse/teachers and the effects of personal and school factors on their performance were covered. The most important constraint on nurse/teachers' preventive mental health performance appeared to be role perception problems by the nurse/teachers or their principals. Implications for nursing education and suggestions for better utilization of school nurse/teachers are discussed.

996. **Cantor, C.L. & Helfat, L. (1976). Training for affective education: A model for change in the schools.** ***Journal of Clinical Child Psychology*, *5*, 5–8.**

A sequentially structured Human Development Program was used to introduce affective education in several primary settings. The program stressed communication skills that promote feelings of awareness, mastery, and social facility. Implementation of the program entailed redefinition of the teacher's role and inservice training, which ranged from individual classroom modeling to workshops. Training served to prepare teachers in the facilitative skills inherent in a mental health curriculum and was based on the principle of protected learning. In training the classroom teacher to become the focal point of the curriculum, individual gains as well as changes in the classroom climate and teacher morale were noted. The program has implications for preventive mental health and the deployment of mental health personnel.

999. **Clemens, N.A. (1976). An intensive course for clergy for death, dying and loss. *Journal of Relgion and Health*, *15*, 223–229.**

A continuing education course for clergymen in mental health, offered at the Department of Psychiatry of Case Western Reserve University School of Medicine, is described. The course, taught by a psychiatrist, studies the human experiences of terminal illness, the loss of loved ones, and other kinds of losses and is taken after a basic 2-year course that deals with interviewing skills, evaluation, short-term crisis counseling, referral, and development of educational and preventive resources of the religious institution. The 10 major areas covered in the third year course are delineated. The case study method is the major method of teaching, but role-playing and outside experts are also used. It is concluded that significant gains were made by the 10 clergymen participating in the course.

998. **Fox, R. (1974). Social agency and school: Training educators to deliver helping services. *Child Welfare*, *53*, 386–393.**

An innovative program designed to train teachers to play an important role in school social work is described. The program yields benefits not only to the children and their families being served but to the agency and its staff. These benefits include: (1) allowing the social agency to offer relevant service directly in the community; (2) extending its interventive skill beyond the strictly therapeutic to preventive strategies; (3) giving the social worker a chance to engage in activities beyond those prescribed by the agency; (4) encouraging schools not only to form collaborative arrangements with service agencies but to have a significant role in planning and implementing programs; (5) offering school professionals the training needed to expand their interventive knowledge and ability to respond to human problems; and (6) benefits to the child, the family, and the community as a result of the integration and interaction between institutional systems that were formerly disparate and noncommunicating. (Author abstract modified)

999. **Santopietro, M., & Rozendal, N.A. Teaching primary prevention in mental health. *Nursing Outlook, 23,* 774–777.**

A newly developed course emphasizing primary preventive care and taught in a basic baccalaureate program in mental health/psychiatric nursing is described. The format, objectives, theories, and skills of the course are discussed as well as the reasons for having such a course and its value. The new course stresses active intervention with high-risk members of the community and sensitivity to the political/economic aspects of prevention.

1000. **Webb, R.A.J., Puren, N., Lonie, D.A., & Leach, A.M.S. (1967). Prevention—an experiment in interdisciplinary cooperation between teachers and mental health workers. *The Medical Journal of Australia,* 204–206.**

This paper describes the aims and programs of the Prevention Committee of Gladesville Hospital, Sydney, Australia. The intent of these programs was to alter community conditions that adversely affect people's development. Because of their formative role with children, school teachers were targeted to receive a training program with three main goals: imparting mental health knowledge, learning how to conduct "pastoral care" with students, and establishing a permanent collaboration between teachers and mental health workers. The various components of the program are briefly described. Teacher reactions to the program, and process issues in conducting it, are mentioned.

See also: 172, 257, 418, 482, 511, 522, 524, 542, 569, 599, 709, 840, 893.

C. Training of Nonprofessionals

1001. **Baker, B., Grant, J., Squires, J., Johnson, P., & Offermann, L. (1981). Parent aides as a preventive intervention strategy. *Children and Youth Services Review, 3,* 115–125.**

This paper examines the role played by parent aides in helping parents to cope with problems of raising children. Both parent aides and parents served were interviewed for their perceptions of what activities are involved in the helping relationship and how crisis situations and problems are handled. A major finding is how parent aides intervene in crisis situations and are able to work out temporary solutions to immediate problems without having to rely on foster care services. (Author abstract)

1002. **Bernard, H.S., Roach, A.M., & Resnick, H. (1981). Training bartenders as helpers on a college campus.** ***Personnel and Guidance Journal, 60,*** **119-121.**

A training program is described that sought to enhance the skills necessary to perform a variety of gatekeeping functions. Student bartenders working in a college rathskeller are portrayed as gatekeepers: individuals at a strategic point of contact between mental health professionals and people in need of such service. The training program, which took the form of a 1-day workshop, included six major segments. Such a workshop is suggested as a potentially useful preventive mental health program for a college campus. (Author abstract modified)

1003. **Collins, A.H. (1973). Natural delivery systems: Accessible sources of power for mental health.** ***American Journal of Orthopsychiatry, 43,*** **46-52.**

A method of identifying, recruiting, and maintaining persons who can provide informal services for their neighbors and assisting them to enlarge their sphere of influence without changing their role and status is described. Their importance as a major, untapped preventive mental health resource is described. Consultation by mental health professionals with natural neighbors in natural systems of service delivery begins with identification of the population to be served and a study of members of that population who have made good adjustments through the help of natural networks. Recruitment of natural neighbors to increase the scope of the natural system and its effectiveness is based on the consultant's offer of collaboration and interest in learning more about the operation of the natural system. Techniques developed for client- and consultee-centered consultation are appropriate for use with natural neighbors and can maintain the natural neighbor in the natural system of service delivery while helping to increase the neighbor's helpfulness. Formal training is contraindicated since each system is unique and there is no applicable knowledge that the consultant could impart to the natural neighbor. (Author abstract modified)

1004. **D'Augelli, A.R., Vallance, T.R., Danish, S.J., Young, E., & Gerdes, L. (1981). The Community Helpers Project: A description of a prevention strategy for rural communities.** ***Journal of Prevention, 1,*** **209-224.**

The Community Helpers Project, a model prevention program that addresses the mental health needs of rural America, is described. The project is designed to enhance helping by rural residents and consists of three training packages: basic helping skills, life development skills, and crisis resolution skills. The objective is to give the average person skills to use in dealing better with common problems brought to them by friends, acquaintances, and family. For all skill areas, the format is based on general instructional principles and includes: identifying explicit behavioral objectives, practice or application of skills to be learned, clarifying by group discussions, presentation of a rationale for learning (understanding of importance of certain skills), sequential presentation, active trainee participation, the use of modeling, and the use of immediate feedback concerning the appropriateness of trainee responses. (Author abstract modified)

1005. **Levy, L. (1973). The role of a natural mental health service delivery system in dealing with basic human problems. In G. Specter (Ed.), *Crisis intervention* (pp. 18–27). New York: Behavioral Publications.**

The role of a natural mental health service delivery system in dealing with basic human problems is discussed. A disease model analogy is provided to contrast the features of natural and contrived external service delivery mechanisms. The medical model is limited and inadequate to deal with mental health delivery. The move toward the delivery of natural services precludes professionalization of the service and denies the utility of the concept of the paraprofessional as a junior grade professional. Natural services are in the interest of primary prevention; the highly trained professional can work in secondary prevention and in the enhancement of the natural support systems.

1006. **Playground instructors learn MH skills (1977). *Innovations, 4*, 29–30.**

A program is described that trains playground instructors in the social and emotional needs of children and in ways to promote children's emotional well-being. Taught by mental health staff members in Luzerne County, Pennsylvania, the course includes: (1) a brief introduction to the idea that playground instructors are more than babysitters; (2) exercises to heighten instructors' awareness of their own importance and increase their sensitivity to children's needs; (3) a didactic section to present various leadership models and theories of authority; (4) discussion of age appropriate behaviors to help instructors become aware of typical situations encountered and activities that might minimize problems; and (5) effectiveness training. The program has been positively received and is viewed as one avenue toward making the playground a target for primary prevention.

1007. Signell, K.A. (1975). **Training nonprofessionals as community instructors: A mental health education model of primary prevention.** *Journal of Community Psychology, 3*, 365–373.

This paper reports some processes that have proven effective in training nonprofessional volunteers to give communication courses in the community. The specific focus of training was to prepare parents from the community to teach other parents in parent–child communication courses. The intensive training program was designed to build confidence and group cohesion through role modeling and practice teaching experience. Key principles in any such training program for nonprofessionals include respect for the feelings of trainees, acknowledgement of the relevance of their own life experiences to the work they are being trained for, and an emphasis on working in pairs to provide mutual support and feedback. The nonprofessionals were trained to instruct in a primary prevention program designed to improve parenting.

1008. Sobey, F. (1970). **Research findings in prevention and innovation.** In F. Sobey (Ed.), *The nonprofessional revolution in mental health* (pp. 122–149). New York: Columbia University Press.

This article analyzes projects utilizing nonprofessionals with regard to how they conformed to definitions of primary, secondary, and tertiary prevention. The great majority of projects involved goals of tertiary prevention, with only one-fifth of the projects involving general community mental health (primary prevention). Those projects characterized as primary prevention typically included screening a total school population in a case-finding effort. There was a relationship between the types of settings and the kinds of preventive projects, with community clinics and social agencies leading in secondary prevention and institutional settings hosting most tertiary efforts. Use of nonprofessionals was clustered around tertiary prevention activities.

See also: 23, 71, 189, 518, 532, 539, 574, 593, 598, 641, 643, 697, 761, 762, 763, 764, 765, 766, 840, 844, 852, 853, 931.

XX. Early Articles in the Field of Primary Prevention

Articles, book chapters, or books involving primary prevention that were published prior to 1960 and that appear in this annotated bibliography are listed in the cross-reference below.

See: 33, 40, 41, 57, 75, 80, 81, 82, 93, 122, 188, 213, 217, 218, 247, 251, 417, 519, 537, 683, 692, 918.

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